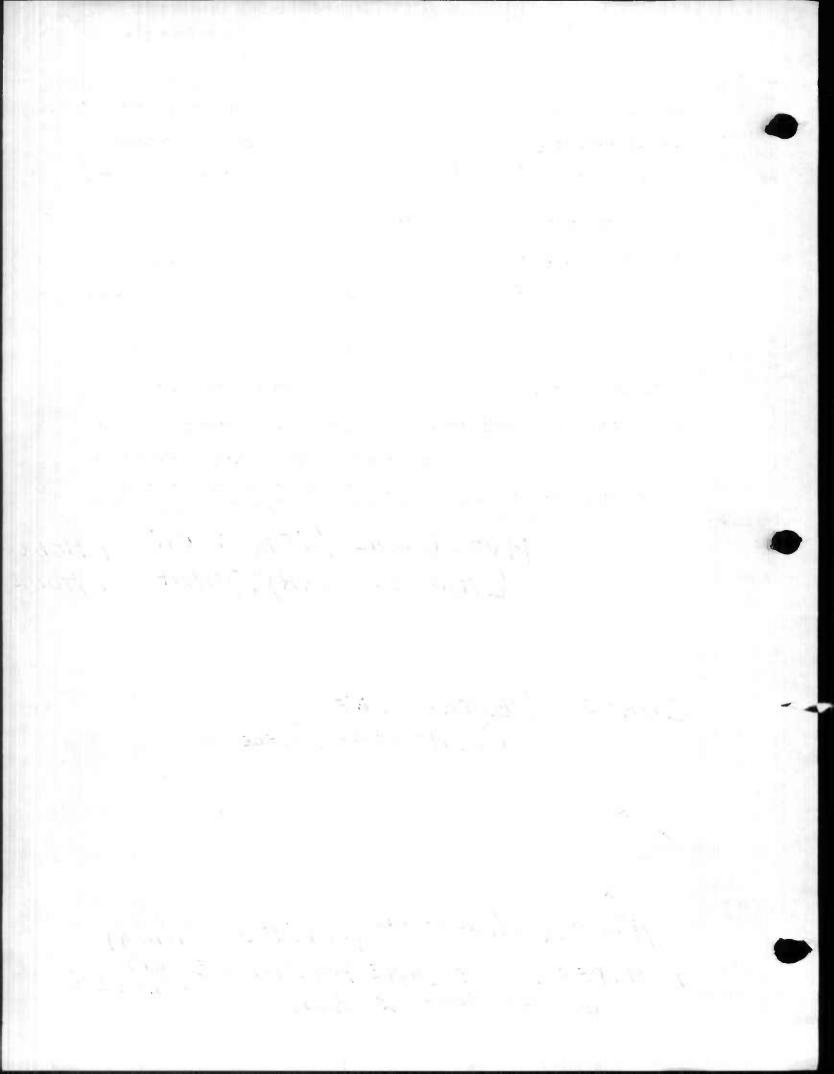
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State of Maryland / Department of Health and Mental Hygiene 9 0 0 5 0 1

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	er de	Funeral	11. Marital Status		12.	Wes Decede Armed Force	s?	S. 13.	Was Decede	ent of l	Hispanic Origin? (Sp ben, Mexican, Puert	pecify Yes or No Rican, etc.)	o- 14.	Raca - Americ Black, White,		
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State Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 12.36 AM ANUAPR Amelia A. Krasauskis 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death NORTH APUNSEL CHEH BURNIE AMMIR ARUNISEL HOCPATAL 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 21X F Maryland 216 07 9533 Yrs 85 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 X No Anne Arundel Glen Burnie Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Mariner Health 21060 U.S. 7355 East Furnace Branch Road Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No 1 Yes 2 No Specify. White If Yes, Give Year or Dates: Specify: 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamentary/Secondary (0-12) Collega (1-4or 5+) Tailor Tailor Shop 10th 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Amelia Beciukaitic Vincentis Cepaitis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, Maryland 21122 Pauline Upton / daughter 2761 Bayside Beach Road 20b. Placa of Disposition (Name of cametary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/9/99 Baltimore, Maryland Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funaral Servica Licenses Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 manuroust arna 23a. Part1. Enter the disea: or shock, or haart failure. List or iphrations that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) OBAR ENRUMONIA Due to (or as a consaquance of): METASTATIC OVARIAN CARCINOMA Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): SPEAST CARUNOMA Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Minknown 24b. Wara autopsy findings available prior to complation of ceuse of daath? 24a. Was an autopsy t □ Yas 2 No 1 Yas 2 No 25. Was case raferred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Euneral** 

Director

r than "netural", or items 23s or 28s-f ahow the Medical Examiner must be notified at

marked other

permit. Pages 1 and 2 s
Department of Health ar
Important: if item 27 is
any injury or other trau

Pages 1 and 2 should be finent of Health and Mental Int: if item 27 is marked or

death

Director

Funeral

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Completed

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that the death certificate be executed bunal-transit and physician s the burial Box 68760. signed by the e P.O. Division of Vital Records. The law requires peed : certificate has page director, this

Physician/Medical

P

Completed

Be

To

Certification:

edicai

Attending Physician: funeral After death. efter death Director: filled in by 6

> State Registra

31. Date filed (Month Page 999

27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature end title of certifier

1 Natural

29c. License number MS

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Phyalcian: To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

28d. Describe how Injury occurred

npleted causa of death (Itam 23a) (Type, Print) 30. Name and odress of parson who co DNA

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

BRIVE GLEN BURNIE MB

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32 Pogistrar's Signifure

24 hours Hospital

To the Hosp within 24 ho To the Fune completely f

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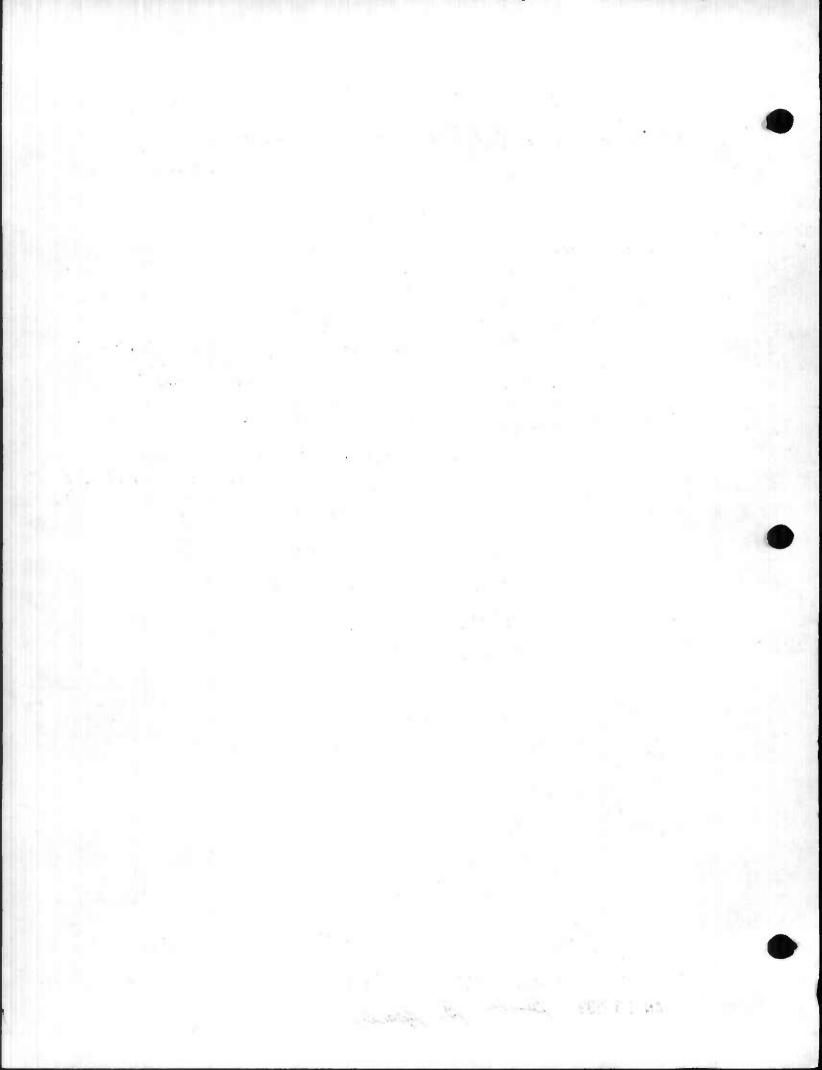
### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0359 Dirwary 08 /Medical 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Dec **Examiner** IMORE N/A Under 24 Hrs If Under 1 Yeer 8. Dete of Birth (Month, Dey, Year) Sept. 27,1913 Security Numbe 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Deys 1 □ M 2 X F Vre 220 22 7511 85 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits the Medical Examiner must be notified at 1 Tyes WIND Director Maryland Anne Arundel Glen Burnie 288-1 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 6 1917 Norman Road 234 21060 U.S. Funerai death 14. Race - American Indian, Black, White, etc. Neme 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Meritel Status Peges 1 and 2 should be filed within 72 hours efter nent of Health and Mental Hygiene. 1 Never Merried 2 Married 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 6 Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Completed by White 3℃ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 10th 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be la marked Georgia Carter James Elliott 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) : If item 27 is Thomas Knight 1917 Norman Road Glen Burnie, Maryland 21060 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 1 ⊠ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Meadowridge Memorial Park 1/11/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility Gonce Funeral Home P.A. namusure 4001 Ritchie Highway Baltimore, Md. 21225 23e. PertY. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner Physician/Medical Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760. Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did tobacco use pontribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☑ No Records. Be Completed by should be 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24e. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 210 No certificate Division of Vital To the Hospital or Attending Physician: 25. Was cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 No edical Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this the funeral 27. Menner of Death Dete of Injury (Month, Dev Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending Investigation 1 ☑ Neturel deeth. 1 Yes 2 No 2 Accident within 24 hours after deet To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 ☐ Homicide 112 Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) and menner stated. 29a. Certifier completely (Check only one) 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ress of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 6:00 AM Daniel J. Moeller DI 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1307 Westellen Road Towson Baltimore If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer) Days Months Hours 10 M 20 F 1911 705-10-8606 Jan. 10, Maryland Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b Counts 1 Tyes 2 The Baltimore Towson 10f Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 21286 USA 1307 Westellen Rd. 14. Rece - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Maritel Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Deles 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementery/Secondery (0-12) College (1-4or 5+) Civil 12 Engineer 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Katherine Watson Moeller Francis 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1307 Westellen Rd. Towson MD. 21286 Virginia Moeller, Wife 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Slete 1 Burlal 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 1/11/99 Dulaney Valley Timonium MD. 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on sections. Approximete Interval Between Onset and Death Metastatic Prostate Carcinoma Immediete Ceuse (Finel GUIS disease or condition resulting in deeth) Sequentially list conditions, if eny, teading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evellable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No 25. Wes case referred to medical 26. Piece of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Neture 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

The lew requires that the death certificate be executed Records, P.O. Box 68760, Division of Vital Physician:

attending physician and for use as the burial-tren signed by the a peen certificate has page director, this After Hospital or Attending | Director: 5 To the Hospital or within 24 hours after To the Funeral Direcompletely filled in the

**Physician** 

/Medical

**Examiner** 

MD

Director

20

Completed

Be

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinat must be notified at

permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important: If Nem 27 is marked ofth any lolury or other traumatic event ance.

**Physician** 

**Examiner** 

Examiner

Physician/Medical

by

Completed

Be

9

Certification:

edical

29a, Certifier

the Maryland

death with

72 hours after

filed within Hygiene.

altimore, Maryland 21215-0020

State Registrar

32. Registrer's Signeture

B. Spark

Falls Rd, DEBORAH A. FRASSICA, M.) 10753

29d. Date signed (Month, Day, Year)

Suite 145, Lutherville, MD 21093

ix Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner as stated.

| Medicat Examinar: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner stated.

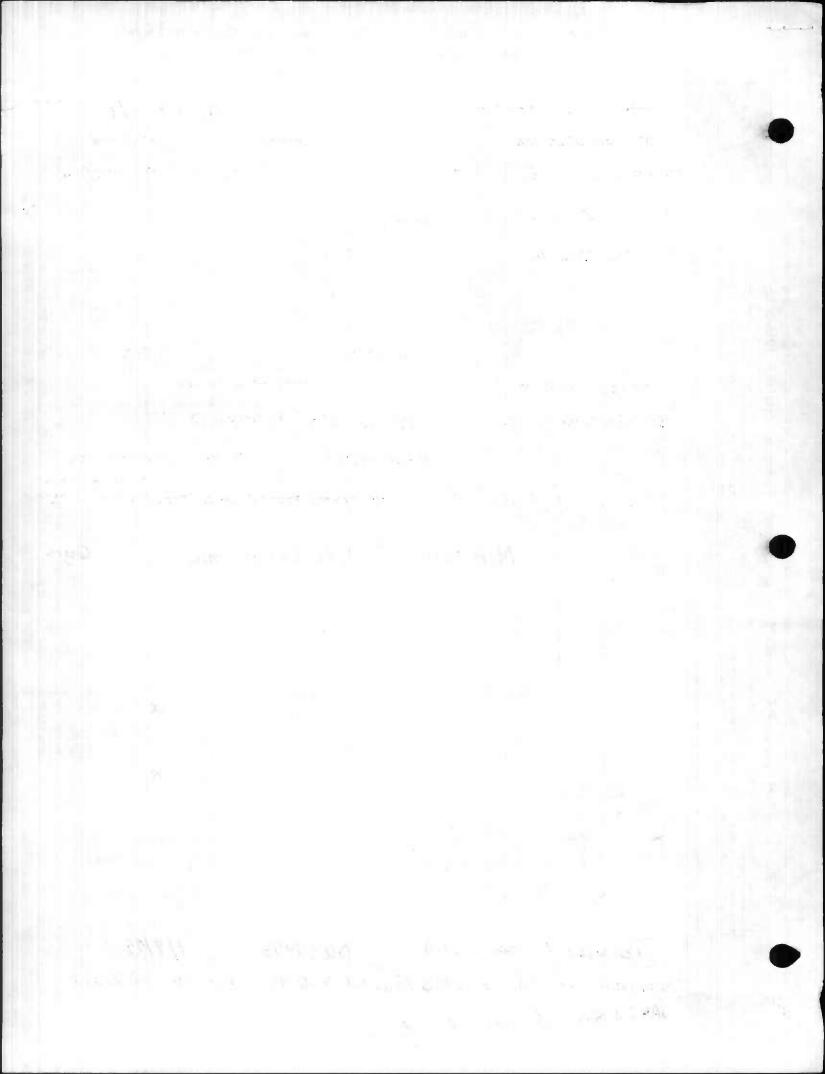
29c. License number

atrussea, mis 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

31. Dete fited (Month, Day, Year)

29b. Signeture end title of cartifier

JAN 1 3 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Physician JAMES G. MERREY JANUARY 5, 1999 11:12 AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE CHARLESTOWN CARE CENTER CATONSVILLE If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funerai** 1 □XM 2 □ F Months Days Hours Min. Director DECEMBER 26,1909 215-07-1122 MARYLAND Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 28a-f show 10d. inside City Limits th and Mental Hygiene. 7 Is marked other than "natural", or items 23s or 28s-f shov traumetic event, its Mocical Examins myst be notified at Director 1 Yes 3 No CATONSVILLE MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #639 719 MAIDEN CHOICE LANE - BROOKSIDE 21228 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces?

1∑ Yes 2 □ No if Yes, Give Year or Dates: WW Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WW II py Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRINTING & PUBLISHING MACHINIST 8TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I int: If Item 27 Is marked or 2 UNKNOWN UNKNOWN 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21228
719 MAIDEN CHOICE LANE-BROOKSIDE#639-CATONSVILLE, MD MARGARET MERREY (WIFE) or other 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 □XBuriai 2 □ Cremetion 3 □ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 1/8/99 WOODLAWN, MARYLAND 21. Signeture of Funeral Servica Licansee 22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. homas 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 uanita 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, an heart failure. List only one cause on each line. Approximate interval Between Onset end Death **Physician** /Medical Immediate Cause (Final Neumonia disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest and Due to (or es e consequença of) physician s the buria Physician/Medical Due to (or as a consequenca of): as esn signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably ( Unknown Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy peed page 2 1 ☐ Yes 20 No this certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) luneral 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation After 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 ☐ Homicide

Box O. م Records, Vital of Division

Jamps

68760,

the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

Attending Physician: Name: ò Hospital
 24 hours a
 Funeral D To the Hosp within 24 hor To the Fune completely fi

death.

State Registrar

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

MI

29c. License number

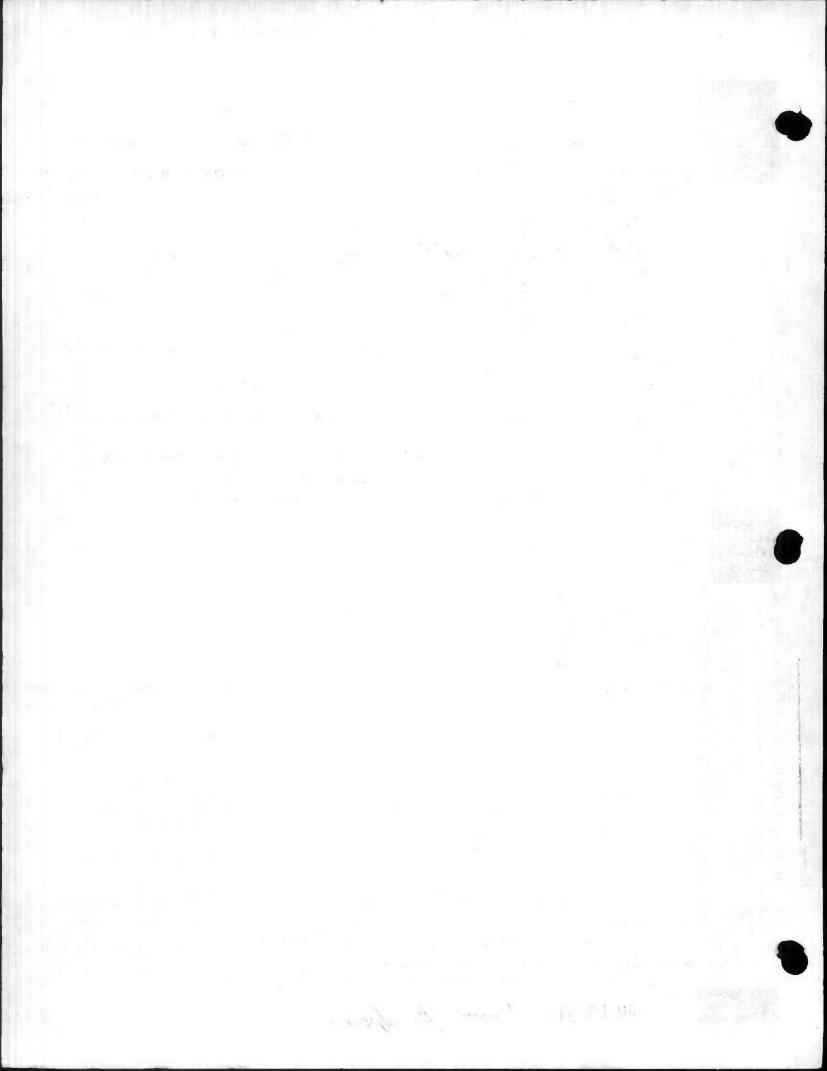
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dav. Year)

hoice

🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Hadrew Maiden 69715

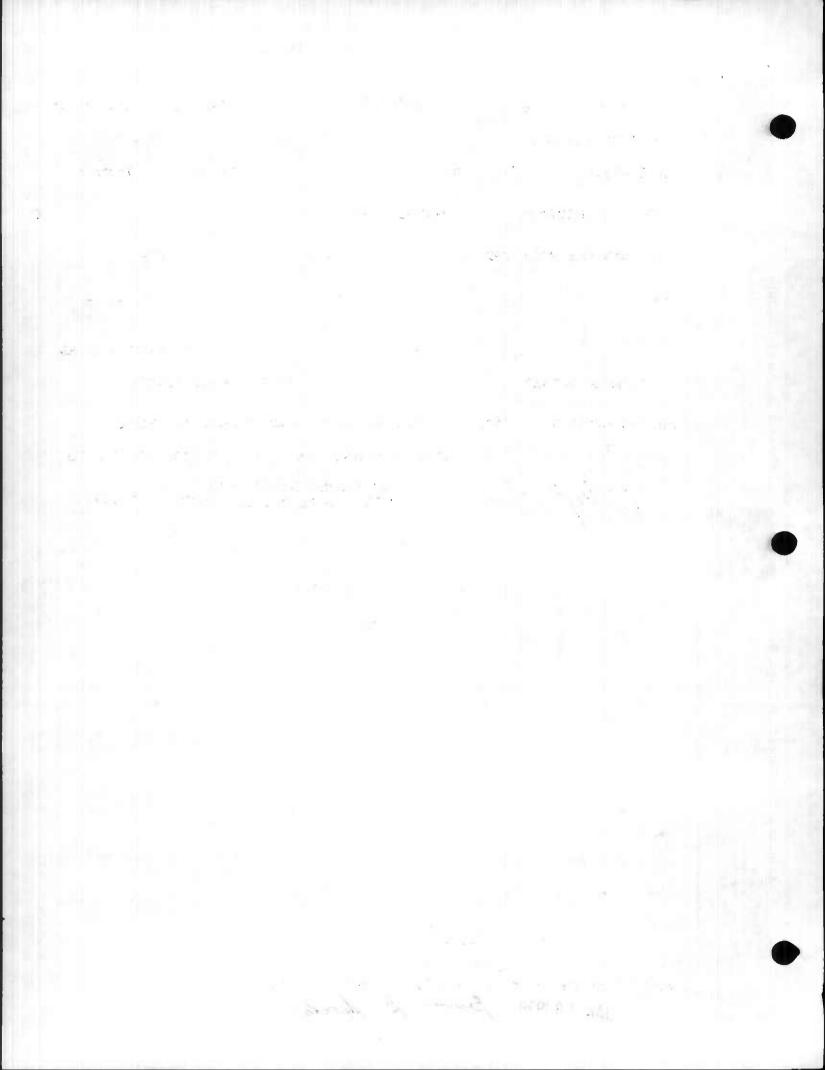
32. Registrar's Signature



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uneral		5. Social Security N			Age (in yrs.	iast birthday		er 1 Yaar							or Foreign
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28a-f show notified at		MD	BALTI	MORE	R	OGERS	FORG	E						1 ☐ Ya	2 No
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niver, must be notified Funeral Director		11. Marital Status	DINCION I	12. Was Deceda	nt Evar in L	I,S. 13.	Was Dec		of Hispanic Origin? (Specify Yes or No Cuban, Mexican, Puarto Rican, etc.)			14. Race -			
ested by Funeral Director		1 ☐ Never Marr	ied 2 Marrled	Armed Force 1 Yes 2 If Yes, Give Year or Data	₹No				Spacify:	arto Ficari, etc./	Black, Whita, atc.  Specify: WHITE				
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To B		WILLIA	M FAIRHU	RST					LOUI	SE IRENE	HOP	KINS			
-		19a. Informant's N	ame/Ralationship	(Type, Print)		19b. Mail	ling Addra	ss (Stree	t and Number or	Rural Route Num	ber, City o	or Town, St	ate, Zip	Coda)	
r F		WITTITAM	марснали	SON		303	לא לא לא	uropi	FF DOAD	TOMEON	MD	21.28	6		
or other traumatic event,  To Be C	2	WILLIAM MARCHANT SON 303 WEATHERBEE ROAD TOWSON, MD 2  20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)  20b. Place of Disposition 20b. Location (Name of cametery, crematory or other place)											wn, State		
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		shock, or hea	irt failure. List only	y one cause on each	line.	in. Do not er	itoi tiio iii	Jue of dy	ing, soon as care	nac or respiratory	arrest,			interval Be	etween
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director, paga To Be Com										1	Yas 2	IZ No	1 🗆	Yes 2	□No
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in by the fune ertification		2 ☐ Accident 3 ☐ Suicide	Investigation	he			М		Yes 2 No						
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State			1011 19	1999	rar's Sign	w /	9	Ana.	KN						
Registrar			INVIO	1333		_	. ,	you	KS/						

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ical iner	4a Facility Name (II	f not institution, give	street and number)				b. City, Town, or I			- 1		
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	5. Social Security No			(In yrs. last b	birthday) If Ur	ndar 1 Yaar	If Under 24 Hrs. Hours Min.	8. Data of Bi (Month, D	rth	9. Birthple	aca (Stata or Fo	
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To Be	George M	itchell					Maude I	anner				
-		me/Ralationship (Ty	ype, Print)	19	9b. Mailing Add	ress (Street			per, City or Town, S	n, Stata, Zip Code)		
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	1 dolm	sund . De	de	Funeral		Dundalk						
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Item 29d Pe	er PHM Film G767 1-13-	99 rja	(	Certificate of	Death		Reg. No.	U	1000						
	1. Decedent's Name (First, Middle, L					2. Date of Dec	ath	Vana	3. Time of Death						
Physiciar /Medica	INFIVE VIEVE	PROVO	NCHE			JANUAR	Y 06 1	999	4.20 PN						
Examine	4a Facility Name (If not institution, g				4b. City, Town, or	Location of Death	_	of Death							
3	HARBOR HOS	PITAL CEN	VTER		BALTI	MORE		N/A							
Funeral Director	Social Security Number 6.	Sex 7. Age (I	n yrs. last birth	day) If Under 1 Yea Months Days					ace (Stata or Foreigr y)						
2 -	Usual Residence of Decedent														
the Marytan r 28a-f show notified at	Maryland Anne An		oc. City, Town Linthi					10	d. Inside City Limits 1 ☐ Yas 2 ☑ No						
or 288-f	10a, Street and Number			10f. Zip Code			10g. Citizen of \	What Counti	y?						
		Road Apt. 2		210	90		U.S								
Nor death v	11. Merital Stetus	12. Wes Decedent Eve Armed Forces?	er in U,S.	13. Was Decedent of It Yes, specify Cu	Hispanic Origin? (5	Specify Yes or No-	14. Rac	e - America ck, White, e							
020 020	3 Widowed 4 □ Divorced	1 Yes 2 No If Yes, Give Yeer or Detes:		1□Yas 2⊠N			Specify		ite						
5-0 72 ho	15. Decedent's I (Specify only highest g	Education	16a. C	Recedent's Usual Occi	upation	rekino	16b. Kind of B	usiness/Indu	ustry						
121215-0 ed within 72 ho system. er than 'natur 4, the Medical.	Elamantary/Secondary (0-12)	College (1-4or 5+)		Give kind of work don ife. DO NOT use retir		anay	ng								
8 4 8 4 6	12th		Г	elegraph (	*		Western Unio								
Maryland 62 should be file by and Mental Hy 7 is marked oth traumatic even	17. Father's Name (First, Middle, Las				18. Mothar's Na	ma (First, Middle,	First, Middle, Maiden Sumame)								
yla Monto	2	Francis Thim			L	aura V.	Mauler								
Agranda and and and and and and and and and	19e. Informant's Name/Relationship			Mailing Addrass (Street		ural Routa Numbe	er, City or Town,	State, Zip (	Code)						
- CHN b					Blvd.										
Pages 1 ent of He mt. if Hen ry or oth		Laura Lee Provonche / Daughter 5625 McClean Blvd.  Baltimore, Maryland 21  20e. Method of Disposition  1 Burial 2 © Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date 20c. Location - City or Town, State													
E de la	4 Donation 5 Other (Spec	Towson	, Mary	vland											
S interest	4 Donation 5 Other (Specify) Hilltop Service Corp.  1/11/99 Towson, Maryland  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Gonce Funeral Home P.A.  4001 Ritchie Highway Baltimore, Md. 21225														
m ases															
	23a. Part1. Enter the disease, or shock, or heart tailure. List on	nplications that caused the	e death. Do no	t enter the mode of d	ring, such as cardia	c or respiratory a	rest,		Approximate interval Between						
Physician /Medical Examiner	Immediata Cause (Final disease or condition resulting in death)	· CONC	EST/	JE HEF	ART F			1 1	Onset and Death						
betu between ansit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last  Due to (or as a consequence of):  DIABETES MELLIT US  Due to (or as a consequence of):  d.														
2 2 2															
dS, P.O. Box rest that the death certification of the attending to detached for use a by Physician M.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contributions														
P.O. dat the dath the dath the datached	Part II. Other significant conditions				given in Part t.		23b. Did tobecco use contribute to the cau								
That that	ALUTE RE	NAL FF	ILUR	E		ייי	188 2LINO	3 Prob	ably 4 tonknow						
Poord require	SEPSIS					24a. Was perlo	an autopsy med?	avsi	re autopsy tindings ilable prior to apletion of cause leath?						
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Vital Rician: The Lician: The Lician: The Lician he rector, page						101		10	Yes 201740						
Of Vita Physician: this certificated director.		Hospital:			ther	ath (Check only o	La- La -								
Physic this of the sel direction.		1 Umpatient		atient 30 DOA	4LI NUISING	Home 5 Resid			1						
Division of the following Part of the following Part of the following of the following Contification.	1 Natural 5 Panding	28a. Date of Injury (Month, Day Yo	ear) 28b. Tir	ury W	ork? ☐ Yas 2 ☐ No	280. Describe i	now injury occur	Teu							
isi isi deati deati the:	2 Accident Investigation 3 Suicide 6 Could not	De Disea of Inium	At home fem			20f Location /	Street and Numb	nor or Phimi	Poudo Number						
or A	4 ☐ Homicide determine	building, etc. (S		n, street, factory, office		City or Tox	vn, State)	rer or marar	riodie Number,						
TEPO C		hysician: To the best of m	y knowledga,	daath occurred at the	time, date and plac	e, and due to the	cause(s) and ma	anner as sta	ated.						
the Hospithin 24 hours the Funer mpletely fill	(Check only 2 Medicat Exa	miner: On the basis of ex and mannar steted	amination and/ l.	or invastigation, in my	opinion, death occ	urred at tha tima,	data end place,	and due to	the cause(s)						
To the Comp	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month.)  P 10640  JANUARY, C														
	Myrx Thom	au, RESI	DEN	rp	10640		JANUA	RY, O	6, 1998						
	30. Name and address of person who	completed cause of death	n (Item 23a) (T	ype, Print) HOSDIT AI	CEN	TER.	BALT	IMOR	E. MD						
State Registrar	31. Date tiled (Month, Day, Year)  JAN 1 3 199	oz. negistiai s	Signature	1-1-1											
riegistrai	ALUL A 192		ful.	paparta											

DHMH 16 Rev 6/95

A STATE OF THE STA

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 3. Tima of Death 2 Date of Death 1. Decedent's Neme (First, Middle, Last) Dey **Physician** JANUARY 6, 1999
ocation of Deeth | 4c. County of Death JOSEPH LED POPE 1999 10:06 AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and numbar) Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) Birthpleca (State or Foreign Country) 5. Social Security Number **Funeral** 10M 20 F Deys Yrs. DEC. 5, 1922 Director 214-18-7902 Usuel Residence of Decadent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No 28a-fr Directo PARKVILLE MD BALTHORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23s or Medical Exeminer must be r U.S.A.

14. Race - American Indian, 21234 3325 ROAD Funeral ACTON 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status Bieck, White, etc. 1 Zyas 2 No If Yes, Give Yaar or Datas: NAVY 1 ☐ Never Married 2 ☐ Married 1 Yas 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highast grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry College (1-4or 5+) Elementery/Secondery (0-12) The FLECTEICAL SUPERVISOR 12 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) 8 2 PHILIP POPE ANGELA CUNED 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) ä Item 27 PARKUIUE, MA. 21234

Dete 20c. Location - City or Town, Stete JUANITA M. POPE, 3325 ACTON RO. SPOUSE altimore, JAN. 9, 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition Pages 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Othar (Specify) 1999 PARKVILLE PARKWOOD CEMETERY 21. Signetare of Funerei Service Licensee 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 23a. Pert1. Entartha disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart fellure. List only one cause on each line. Approximete Interval Between Onsat end Deeth **Physician** Immediete Ceuse (Final diseese or condition resulting in death) /Medical RESPIRATORY FAILURE 30 MIN. **Examiner** Due to (or es e consequence of) Examiner physician and the buriel-transit requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequenca of): 80 attending 950 ed by the a 23b. Did tobacco use contributs to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Unknown 1 Yes 2 No 3 Probably CARDIAC ARRHYTHMIA Records, by 24b. Were autopsy findings evalleble prior to been si 24e. Wes en eutopsy performed? Completed CHRONIC OBSTRUCTIVE PULMONARY DISEASE completion of cause of death? The law page 2 certificate hes 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Wes case referred to medical exeminer? Be 28. Piece of Deeth (Check only one) exeminer? Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this After this 28d. Describe how Injury occurred 27. Meaner of Deet 28b. Time of 28c. Injury et Work? Certification: 1 Neturel
2 Accident 5 Pending investigation Attending ofter death.

Director: Aff 1 Yes 2 No 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Sulcide 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide the Funeral Dit the Funeral Di Hospital 1) Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. edicai 29e, Certifier (Check only one) To the Vithin 2 29d. Date signed (Month, Dey, Year) 29c. Licanse number 29b. Signature and title of cartifier 1-6-99 D30263 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) FRANCIS 7620 YORK ROAD. TOWSON. MARYLAND 21204 KHOO. M.D. 31. Dete filed (Month, Dev. Year) 1 3 1999 32. Registrar's Signeture State souls Registra ---**DHMH 16 Rev 6/95** 

81 BAN 2 DA E S LOVE SSCHOOLS 3 1 1 1 2 3 3 Y.J. B. M. galakonia ku liborah akari MERICAN DECIMENT AND ADDITIONS OF THE

						(	Certific	ate of	Death			Reg. No.		Dair	,
		1. Decedent's Nam	na (First, Middla	, Last)							2. Date of De	ath	V	3. Tima of I	Death
	/sician ledical	Mary	C.		Palewi	CZ					January	<sup>Day</sup> , 19	99	11:00	a.m.
	aminer	4a Facility Nama (	If not institution,	give street and i	rumber)				4b. City, To	wn, or Lo	cation of Death	4c. County	of Death		
<b>(</b> 0)		6401 Lo	ch Rave	n Boulev	ard				Baltin	mcre		N/A			
Fune	eral	5. Social Security	Number	6. Sex	7. Aga (In	yrs. last birth	day) If Un	dar 1 Yaar	-	24 Hrs. Min.	8. Data of Birt	h Veerl	9. Birthp	olaca (Stata or	Foraign
Direc	tor	212-09-	2355	1□M 2ØF	1	34 Yr	S.	Days	riouis	IVIII 1.	April .	3, 1914	Balt	imore	Md.
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yla Men	To			Benjam	iin ke	bstock					Annie	Hertzbu	rger		
Mar 2 sh and te m	range	19a. Informant's Name/Ralationship (Type, Print)  Albert W. Palewicz (Son)  19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Standard Street and Number or Rural Routa N													
* E3M	1	20a. Mathod of Disposition 20b. Place of Disposition (Nama of Date 2													6
Baltimore	6			3 □Removal from	m State	camatary,	crematory o	or othar pla				20c. Location -			
ting by	Anna	4 Donation 5 Other (Specify) Holy Cross Cemetery 1/12/99 Brooklyn Ma 21. Signatura of Funaral Sarvice Licensee Milton J Knight Jr Lecnard J. Ruck, Inc. Funeral Home													
Ba and	SDC8														
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exact n and	Examiner	Sequentially list co if any, laading to in causa. Entar Undo Cause (Disaasa or	nditions, nmadiate		Dua t	o (or as a co	nsequence	01):					1		- 2
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certificate be executed rightly physician and	E 5	rasulting in death)	Last		Dout	0 (01 83 8 00)	isoquarico (	,,,					1		
W 2 '	- N			d											
	Physician/	Part II. Other signif	licant condition	s contributing to	death but not	rasulting in t	ha underlyin	g causa gi	ven in Part I	1,	23b. Dld	lobacco uss con	tributs to	o the causs o	f death?
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cords, requires been sign	<b>5</b>		la	BARS	15/00						24a. Was	an autopsy med?	av	are autopsy fin ailable prior to	
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ysiciani The	Be C	25. Was casa rafar examinar?	red to medical						26. Place	a of Death	n (Check only o	ene)		,	
Of Vita Physician: this certific	10	1□ Yas 2	No	Hospital:	Inpatiant :	2 ☐ ER/Outp	atient 3	DOA		ursing Ho	ma J Rasi	dance 8 Othe	r (Specil	(y)	
On Of Office this		27. Manner of Deat	h 5 ☐ Panding	/8.4.	a of Injury onth, Day Yea	28b. Tin inju	iry	28c. inju Wo		_	28d. Describe	now Injury occurr	ed		
Division to Attending after death. Director: After	8 8	2 Accidant	Invastige	ation of be	on M 1 Yas 2 No										
Division of the death after death Director: /	rtiff	3 ☐ Suicide 4 ☐ Homicida	determin	ned 288. Pla	ce of Injury - A Iding, atc. (Sp	t homa, farm	, street, fac	tory, office			28f. Location (: City or Tox	Street end Numb vn, State)	er or Rure	el Route Numb	oer,
D = 000	8 0														

Medical (

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifian

29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Common lowe M.D. 7672 Belair Rd.

Baltimore, Md.

State Registrar

31. Date filed (Month, Day, Year) JAN 1 3 1999

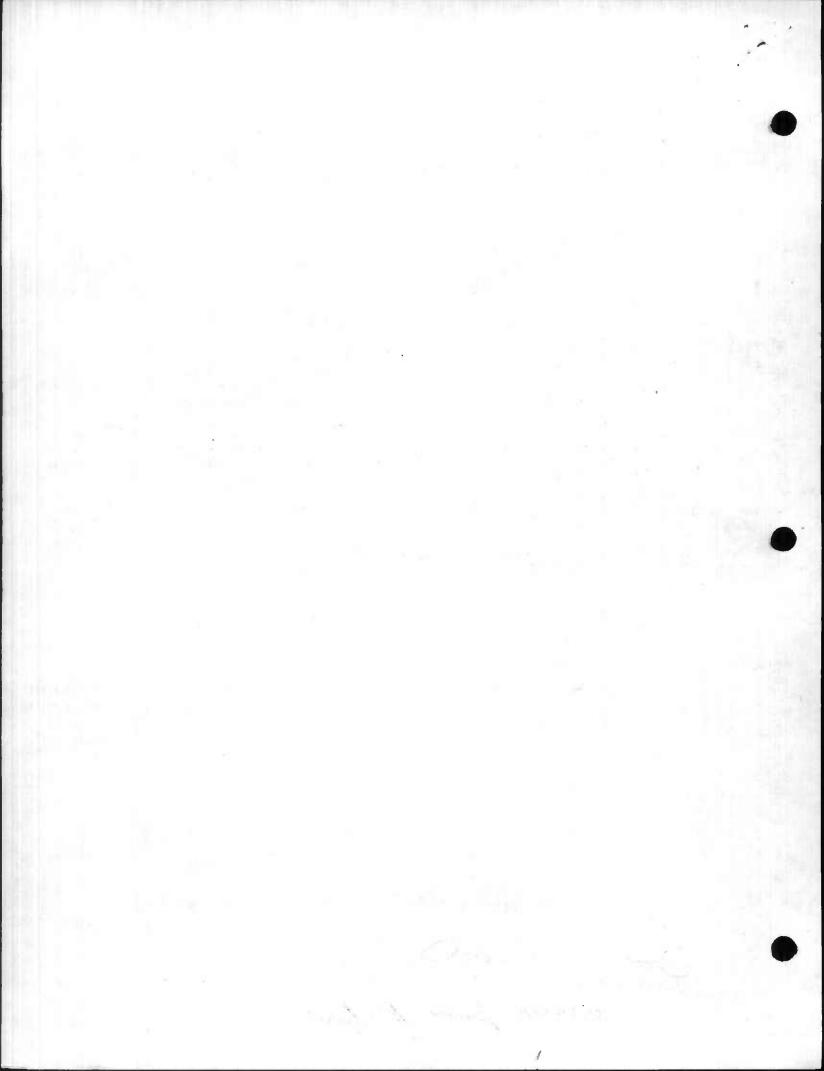
32. Registrar's Signature

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

MABEL RIE	S	State of Marylar		ent of Healtr ate of Deat		ntal Hygle Reg.	77	00	511
Physician /Medical	1. Decedent's Name (First, Middle, Last	Ries					Day 1999	Year	3. Time of Death 10:26 AM
Examiner	4a Facility Name (If not institution, give JOHNS HOPKINS H	street and number) HOSPITAL E.R.		4b. City, BA	Town, or Local	ion of Death	4c. County	of Death	
Funeral Director	214-30-0079	7. Age (In yrs.	last birthday) If Und Month		der 24 Hrs. 8. s Min.	Date of Birth (Month, Day, Y	1931	9. Birthplac Country	e (State or Foreign
Maryland of show	Usual Residence of Decedent  10s. State 10b. County	10c. Ci	ty, Town or Location	) ()		,		10d.	Inside City Limits
or 28s	10e. Street and Number	11 51	101.	Zip Code	3	109	Citizen of V	Vhat Country	?
Maryland 21215-0020 d 2 should be filled within 72 hours after death with the Maryland th and Maniel Hygiene. 7 is marked other than "natural", or items 23s or 23s-f show traumatic event, the Medical Exeminat must be notified. To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 W No If Yes, Give	If Yes, s	cedent of Hispanic loecify Cuban, Mexico	can, Puerto Ric	y Yas or No- an, etc.)		e - Amarican k, White, etc	
21215-0020 d within 72 hours at giene. If then "natural", or then "natural", or the state of the	3  Widowed 4  □ Divorced  15. Decedent's Edu (Specify only highest grad  Elementary/Secondary (0-12)		16a. Decedent's U (Giva kind of life. DO NOT	work done during m	nost of working	16	b. Kind of Bu	isiness/indus	try
Maryjand 21215-0 d 2 should be filed within 72 ho th and Mentel Hygiene. 7 is marked other than "nature traumatic event, the	17. Father's Name (First, Middle, Last)	oemakor	HOMON	18. Mo	other's Name (F	irst, Middle, Ma			
of Heal	19a. Ipformant's Name/Relationship (7)  20a. Method of Disposition  1 2 Burial 2 Cremation 3 F	Rill R 206. 1	19b. Mailing Addre		St. 1	Balti	MORE	State, Zip Co	21231
Baltimore, permit, Pages 1 en Department of Healt Important: If Item 2 eny Injury or other ands.	4 □ Donation 5 □ Other (Specify)  21. Signature of Edneral Service Licens	PO	22. Nama	and Address of Fac	cility Eva	us Cha	arky	ILL. A Men	Md.
Physician /Medical	23a. Part1. Enter the disease, or compishock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)	ne cause on each line.		iovascula			•	ln:	pproximate telerval Between nset and Death
58760, cete be executed physician and s the burial-transit adfcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter linearthing	bDue to (c	or as a consequence of	f):				1	
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	25. Was case referred to medical			26. Pl	ace of Death (0	1 ☐ Yes	XX No	1 U Y	res 2□ No
0 4 5 5	XXX 162 ZI NO	lospital: 1 Inpatient			- 1	5 Residence			
DIVISION OF VITA  Let or Attanding Physician: To after death. To Director: After this certificial in by the funeral director.  Certification: To Be	27. Manner of Death  12. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2	□No	Describe how     Location (Street	et and Numb	H.	Route Number,
- 555c E	29a. Certifier 1 Certifying Phys	building, etc. (Specifical Specifical Specif	y) 	od at the time, date			se(s) and ma		
To the Hospital of within 24 hours of To the Funerel Discompletely filled is Medical Celebrate C	29b. Signaldre and title of certifier	ner: On the basis of examina and manner stated.		9c. License numbe	Ðr.			d (Month, Da	
	30. Nagrie and address of person who oc	empleted cause of death (Item	n 23a) (Type, Print)	O.C.M.					
State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	11 Penn St	reet, Ba	Limore	, maryl	and 2.	.ZU1	

DHMH 16 Rev 6/95

ORIGINAL.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death T. Docedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:45An. KOBERTSON 1999 AROLYA J2RRi2 JAMUARVIZ /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner BSL A, R

If Under 24 Hrs. 8. Dete of Birth
Min. (Month, Day, Yeer) HARFORD 1406 KOYAL OURT Room ff Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 254F 239 66 7226 Usual Residence of Decedent Yrs. 55 Ozt.17.1943 Director norTHIAROLINA the Marylend 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 Yes 2 No BELATR Directo HARFORD malusam 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be a .A 2-6 ROOM 21012 140b Funeral filed within 72 hours after death Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11 Marital Status Bleck, White, etc. 1 ☐ Yes 250 No If Yes, Give Year or Dates: 1 Never Merried ≥ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 27 RS HomemakeR AT HOME 12YRS permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked other any Injury or other traumatic event pace. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILBUR ARSONS Hobson GLAPYS Lo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROBERTZON T BIL AIR, MARYLAND 20c. Location - City or Town, State KOYAL KENTS ROOM LOURT 1406 20b. Place of Disposition (Name of comelery, cremetory or other place)

CARP GROUNDY COMERCE

RETHOUGHTER 20a. Method of Disposition Date JAn. 16 1⊠Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 1999 FAYITTEVILLE 22. Name and Address of Facility OFBELRIR, P.A. 21. Signature of Funeral Service Licensee 21030 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on pech line. 19RYLAND Approximate Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting In death) week /Medical **Examiner** Carcinona, small cell Physician/Medical Examiner The lew requires that the death certificate be executed ettending physician and for use es the bunel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events P.O. Box 68760, thet initieted events resulting in death) Last Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t of carci 1 Yes 254 No 3 Probably 4 Unknown Division of Vital Records, P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed this certificate he 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was cese referred to medice! 26. Place of Death (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 □ Nursing Home 5 Residence 6 □ Other (Specify) P 1 Yes 25 No 27. Manner of Deeth 28d. Describe how injury occurred Certification: Injury et Work? I or Attending P After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: / 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours af To the Funeral DI completely filled in Hospital TS Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the candidate and manner stated.

State

Registrar

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29a. Certifier

29b. Signature and

30. Name and ad

31. Date filed ( onth, Day, Year) JAN 1 3 1999

200 32. Registrar's Signature

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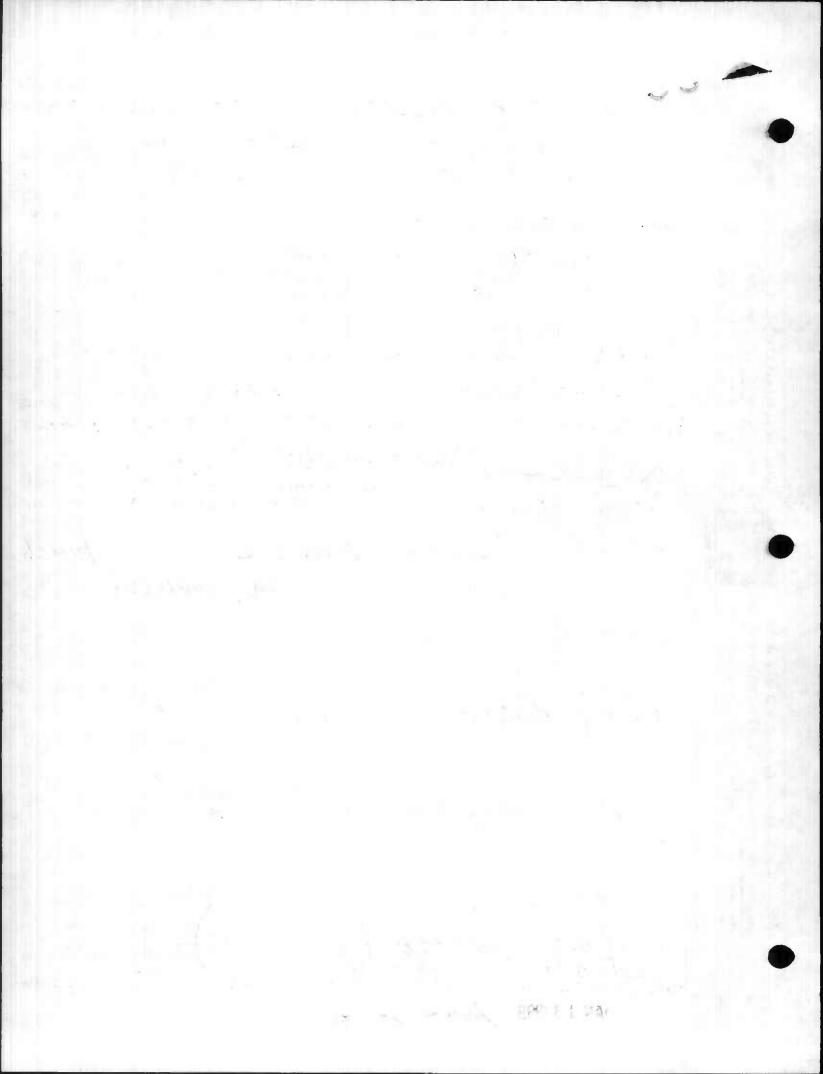
29c. License number

ne, date and place, and due to the cause(s)

29d. Date signed (Month, Dey, Year)

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To the within 2



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Rodgers, William

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary 01ive Rhoten 8, 1999 8:34PM JANUARY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE Hours Min. 8. Date of Birth (Month, Day, Year) 01/06/1923 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 1 □ M 2 14 F Months Days 216-14-3143 76 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. inside City Limits 1 ☐ Yes 2 € No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 43 Acorn Circle Apt. 201 21286 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Yeer or Dates: 11. Meritel Stetus Wes Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 Midowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Margaret Anna Poteet Harvey B. Rembold 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Jaime C. Cook (granddaughter) 597 Oakland Hill Drive Apt. A-2 Arnold, MD. 21012 20b. Plece of Disposition (Name of cemetery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete Donetlon 5 Other (Specify) Hilltop Service Corp. 01/11/99 Towson, MD. 21 Singature of Funeral Service Licensee Dennis C. Carroll<sub>22</sub> Name and Address of FacilityRuck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 Part. Fund the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, mode or heart feilure. List only one cause on each line. Approximete Interval Bet Onset end Deeth Immediate Cause (Final diseese or condition resulting in death) Due to (or as a consequ reumoned Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): COP Due to (or es e consequence of): mol enone Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of seeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat exeminer? 26. Place of Deeth (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Mannef of Deeth 28c. tnjury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homlcide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) end manner stated.

29c. License number

29d. Days signed (Month, Day, Year)

/Medical Examiner Box 68760. Records, P.O. Division of Vital

**Physician** 

Examiner

Director

Funeral

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After

Baltimore, Maryland 21215-0020

Rhoten,

/Medical

death certificate be To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After

Registrar

31. Dete fited (Month, Day, Year) JAN 1 3 1999

(Check only one)

29b. Signature end title of pertification

660 KENKWONTH PM. TUWSON, MR. 21204 HERLIHY MO. 32. Registrar's Signature

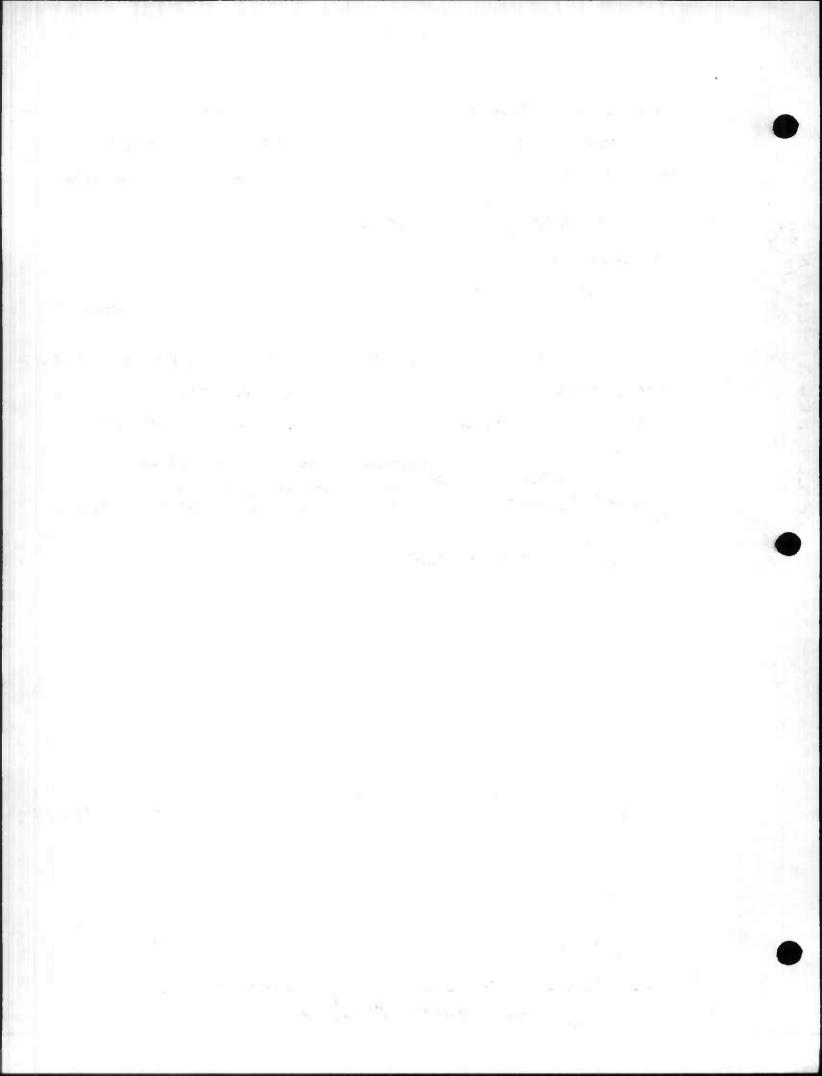
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

17. 17.

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## HELER FRANCES REVILLY-RECO ## HELER FRANCES REVIEW REVIEW REVILLY-RECO ## HELER FRANCES REVIEW RE		_					(	Certifica	ate of	f Death		Reg. No.		udi J		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 23part I, per M.D G-767 1/13/99 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Dey reiton 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Maryland Baltimore Baltimore, MD 5. Social Security Number 0 If Under 24 Hrs. 8. Dete of Birth (Month, Day Birthplace (State or Foreign Country). 7. Age (In yrs. last birthday) Min. 1□#M 2□ F 45 Months Days Hours Wir.C. 245 82 8537 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1∰ Yes 2□ No MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 HOLLINS ST. 21223 USA 12. Was Decedent Ever In U,S. Armed Forces?
1 口 Yes 2 即 No Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1# Never Merried 2 ☐ Married 1 ☐ Yes 2 # No Specify: If Yes, Give Year or Dates: Specify: AFRO AMERICAN 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION CO. SKILL LABORER 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) LUTHER RUFFIN JULIA RUFFIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY RUFFIN 3705 MOHAWK AVE. BALTO. MD. 21207 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ∰ Buriat 2 ☐ Cremation 3 ☐ Removal from State RUFFIN CEMETERY 1/9/99 EDGECOMB CO. N.C. 4 ☐ Donetion 5 ☐ Other (Specify) ESTEP BROTHERS 1300 EUTAW PL. 21. Signeture of Funeral Service Licensee FUNERAL HOME MD. BALTO. e, or complications that caused the List only one cause on each line sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DOXIG Due to (or as a consequenca of): 1/0/10/1 Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee No 3 Probably 4 Unknown 24a. Wes an autopsy performed? Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25€No 1 Nunpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

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or Attending Physician: funeral director, After this after death. Director: Aft Hospital 24 hours

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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To

Examiner

Physician/Medical

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Certification:

Medical

29a. Certifier

(Check only one)

7 is marked other than "natural", or flams 23a or 28a-f shor traumatic event, the Medical Expression must be multified at

8 Department Important: Il

**Physician** 

Examiner

/Medical

Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

with the Maryland

death

State Registrar

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vithin 2 To the

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and placa, end due to the cause(s) end manner stated.

4 certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

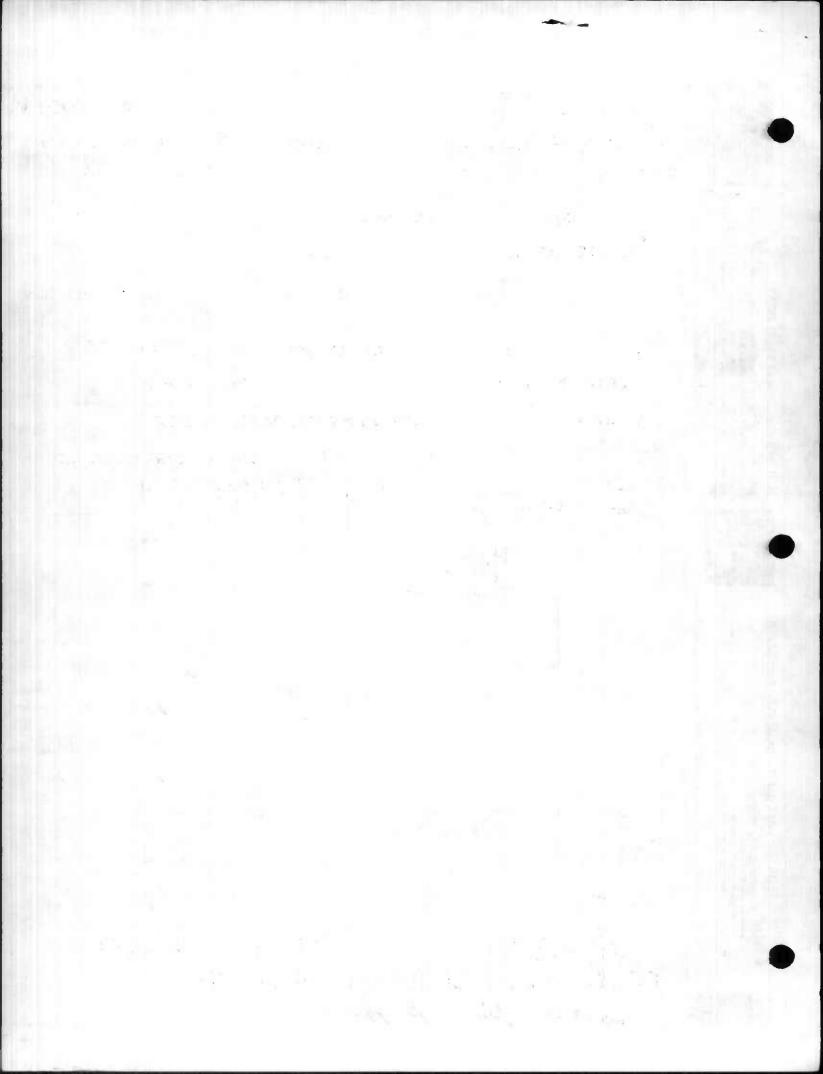
29b. Signature and 36

30. Name and add ess of person who completed cause of death (Hem 23e) (Type, Print)

Maryland 0

31. Date filed (Month, Day, Year)

JAN 1 3 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Vee **Physician** ELNORA STEWART MARGARET JANUARY 1999 23.10 7 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner UNION MEMORIAL HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Deys 1 M 2 F 213-70-0175 40 Yrs. Director 04-20-58 MD Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f short the Medical Examiner must be notified at MD NA Director Baltimore 1 Yes 2 No 10e Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 3101 Lawnview Avenue 21213 Funeral USA 14. Reca - American Indien, 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2 No 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2₺ No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Fresenias Medical 12th Grade 3yrs. Disabled Care 7 is marked other treumstic event, 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Peges 1 end 2 should be nent of Health and Mentel Charles H. Harding Elizabeth Draper 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 19e. Informent's Neme/Reletionship (Type, Print) Health 8 Elizabeth+Juanita Stewart 3101 Lawnview Avenue Baltimore, Maryland or other 1 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from State rtment 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore Cemetery 01-15-99 Baltimore, MD 22. Name end Address of Feclify Baltimore, Maryland 21202 21. Signeture of Funeral Service Licensee WM.C.March FH 1101 E. North Avenue 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician 5 month /Medical Immediate Ceuse (Finel Cancer disease or condition resulting in deeth) Due to (or es a consequence ot) Examiner physician and the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medicai Due to (or es e consequence of) Margaret Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of desth? 1 Yes 2 No 3 Probably 4 Nunknown hyper Cal cemia à 24b. Were autopsy tindings aveileble prior to 24a. Wes en eutopsy performed? Completed completion of cause of death? 2 No 1 ☐ Yes 25 No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 Napatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No funeral 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? VXNaturel 2 ☐ Accident Division 5 Pending death. 1 Yes 2 No investigetion after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 6 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner as steted. To the Hosp within 24 ho To the Fune completely f (Check only one) 2 Medicat Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) muchy, M.O. AT 24389 46 C12 January 7 30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print) 201 E. UNIVERSITY PKWY

UNION MEMORIAL HOSPITAL

BALTIMORE, MD 21218

Registrar DHMH 16 Rev 6/95

State

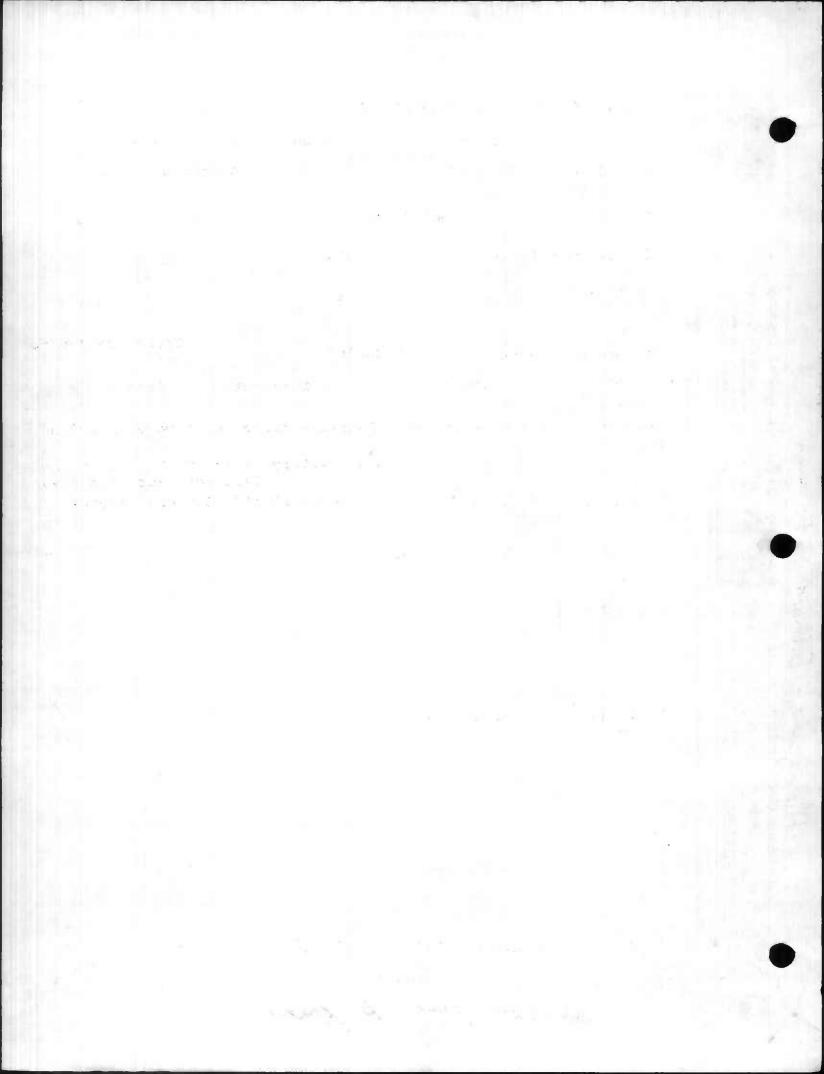
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JAN 1 3 1999 --- 0 , 1 7007

32. Registrer's Signeture

HUSAM SEMAAN, M.O.

31. Dete filed (Month, Day, Year)

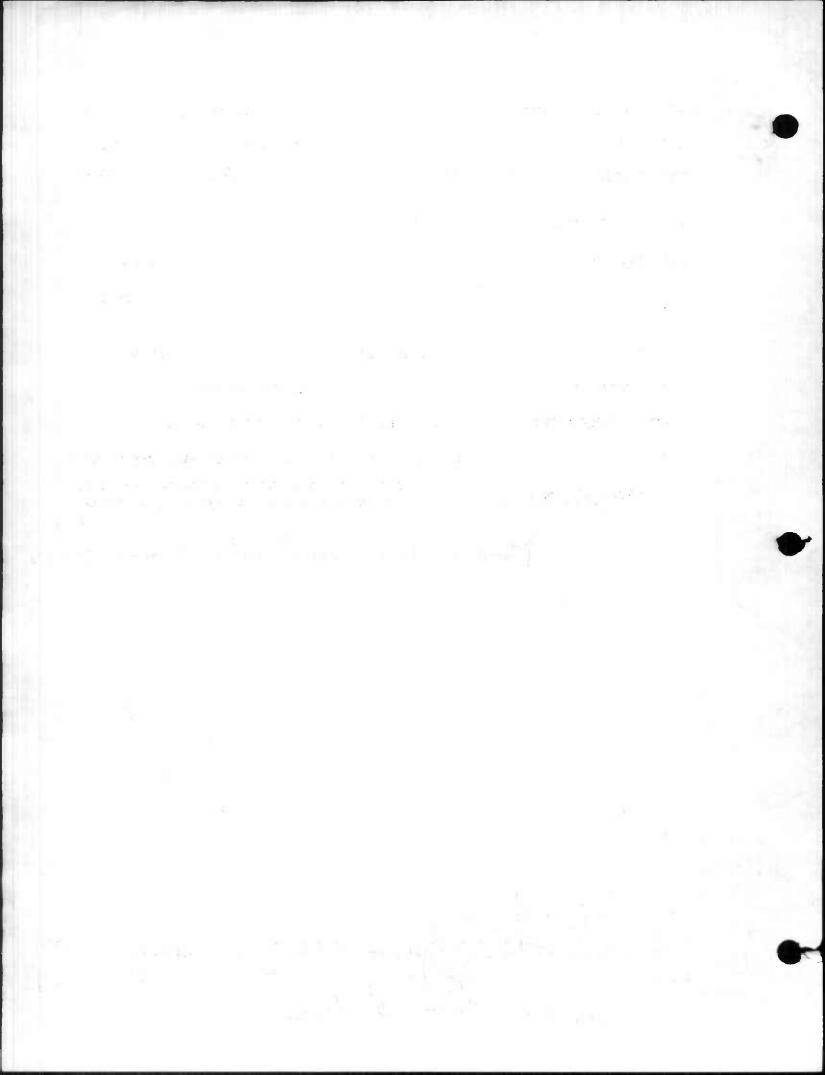


### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year JANUARY 11, ALVINA ALBERTA SMITH 1999 /Medical 3:50PM 4a. Facility Name (If not institution, give straet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1146 ELM ROAD ARBUTUS BALTIMORE 5. Social Sacurity Number If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/18/1924 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MARYLAND **Funeral** Days Hours 1 M 2 □XF 74 Yrs. Director 216-20-1660 Usual Residence of Decedent death with the Marylend 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 ☐ Yas 2X No Director BALTIMORE ARBUTUS 10e. Straat and Number 10f. Zip Coda 10g. Citizen of What Country? Funeral 1146 ELM ROAD U.S.A.

14. Race - American Indian,
Black, White, etc. 21227 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Datas: 1 Never Married 2 ☐ Married 21215-0020 þ 1 Yes 2 No Specify: Specify: WHITE 3 ₩ Widowad 4 Divorcad jes 1 and 2 should be filed within .....
tof Health and Mentel Hygiene.
Hitem 27 is marked other than "natural".
Hitem 27 is marked other than "natural". Completed 18a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Dacadent's Education 16b. Kind of Business/Industry (Specify only highest grada completed) Elementary/Sacondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME Baltimore, Maryland 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be JAMES MAJEWSKI FRANCES SMOLSKI 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) KAREN BRYANT/DAUGHTER 242 CINMAR ROAD GLEN BURNIE, MD 21060 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Peges 1 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State 1 0 permit. Pege Department of Important: If any injury or 4 ☐ Donation 5 ☐ Othar (Specify) LAKEVIEW MEMORIAL PARK 1/15/99 SYKESVILLE, MD 21. Signatura of Funeral Service Licanses 22. Nama and Address of Facility STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or haart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequance of): Physician/Medical Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disaase or Injury that initiated average) Due to (or as a consequence of): Box 68760. physician that initiated avants rasulting in death) Last Due to (or as a consequence of): 98 980 Po Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 0 been signed by the should be detached 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 0 1 ☐ Yss 2 ☐ No Records. þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 hes 1□ Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, Be 25. Was cese refarred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital; 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Certification: To After this 27. Mapner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Natural 2 Accident efter death. Director: Af 1 Tyes 2 No the 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 □ Ho 24 hours e Hospital 29a Cortifie Cartifying Physic o tha best of my knowladga, daath occurred at the tima, data and place, and dua to tha causa(s) and manner as stated Medicai On the basis of ax manner states completely mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 ş 29d. Data signed (Month, Day, Year) 0 pe, Print) Name and addrass of person BANNORE AMAI DRIFFITIS 31. Date filad (Month, Day, Year) 32. H State 1 3 1999 Registrar



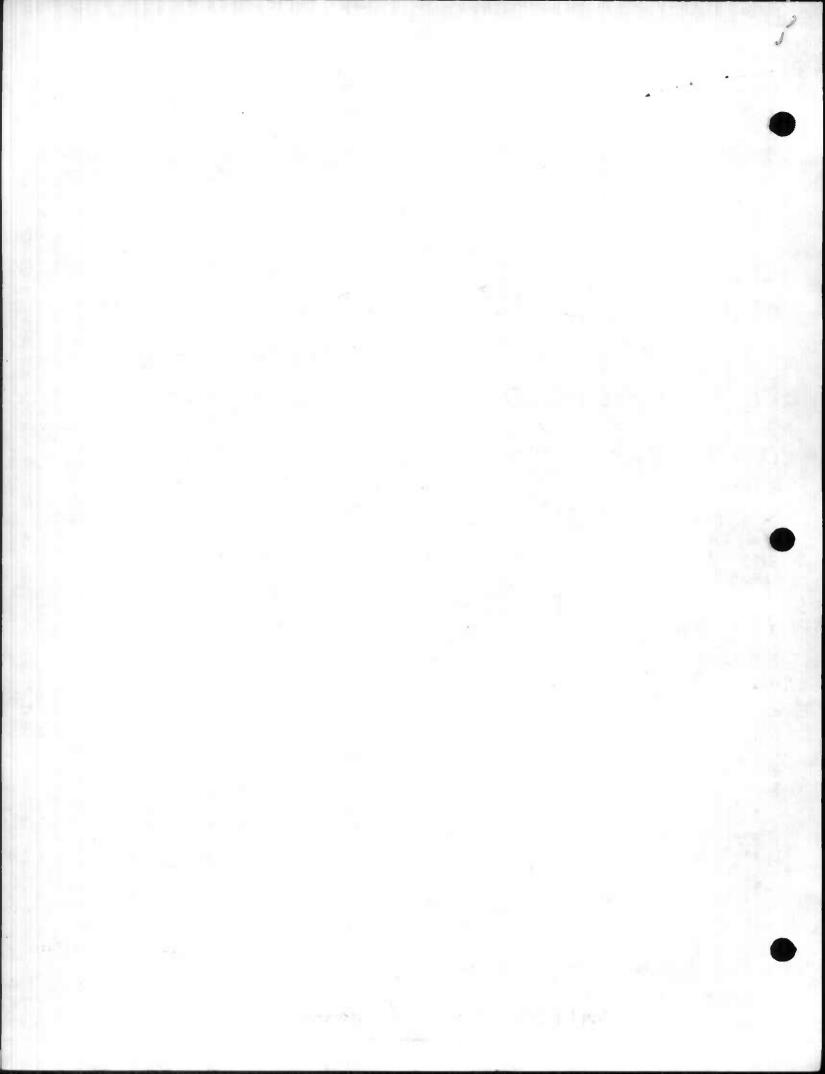
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day 37 **Physician** STEVENS SR CLARIALS anuary MAILI /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street end number) **Examiner** FAUSTON If Under 24 Hrs. HARFORE TOSRA HOSPITAL 10012LLA-1 8. Date of Birth (Month, Day, Year) # Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days Months Hours 42 043L 15€ M 2 F PORDAJ Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director HARFORD MARYAM 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? b munt be 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) KOAC Barns 23a DOOWSLINK 1.2.V Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 1 Yes 25 No If Yes, Give Yeer or Detes: 1 Never Married Merried 8 Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 Divorced STIKE 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) MYRS. TIR-AD SITTER BALTIMORE Department of Haath and Adntal Hy important: If Item 27 is marked other any Injury or other 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) 88 STEVERS LUCY AND BUDGELS PLYXANDER 19b. Meiting Address (Street and Number or Rurat Route Number, City or Town, State, Zip Code) t9a. Informent's Neme/Reletionship (Type, Print) BURIR AIR MARYLANO
20c. Location - City or Town, State ROSANNA L. STEVENS HILLSWOOD KOAD Baltimore, 20b. Plece of Disposition (Name of cemetery cremetory or other plece) 20a. Method of Disposition Data JA916 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 □ Donation 5 □ Other (Specify) TEA. 1999 FORESTHU 21. Signature of Funerel Service Licenses 22. Name and Address of Fecility CHAPSI—BUATR, P.A. 3 DEWPORT DRIVE FOREST HILL MARYLARD. 23a. Pert1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on sech lina. Approximete Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Finel HEART FAILIURE CONGESTIVE disease or condition rasulting in death) Examiner ESPIRATORY FAILIURE Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Lest Dua to (or as e consequence of): physician a Box 68760. LYDCARDIAL INFARCTION Physician/Medical Due to (or es a consequence of): 23b. Did tobacco use coptribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 1 | Yes 2 No 3 | Probably 4 | Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Mennar of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? e Hospital or Attending P n 24 hours after death. e Funeral Director: After t Certification: After Neturel 5 Pending 1 Yes 2 No investigetion 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) To the F within 2 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number JANUARY WWD. h 30. Nema end addrass of person who completed cause of death (Item 23a) (Type, Print) 424 F. MAHMOOD SUITE BEL AIR M.D NORTH AVENUE MARYLAND 21014 31. Data filad (Month, Dey, Year) 32. Registrar's Signatura State Registrar JAN 1 3 1999

aren co

**DHMH 16 Ray 6/95** 

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month CHARLES **Physician** 345 PM SC077 06 99 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Lorien Nursing Home Howard Columbia If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Jan. 18, 1909 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Funeral Days Months Hours Illinois 110 M 2□ F 89 Yrs. 316-16-1069 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at 1 Yes 2X No MD Baltimore Director Freeland 10e Street and Number 10f Zio Code 10g Citizen of What Country? 21053 U.S.A. 19419 Spook Hill Rd. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11 Merital Stalus permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiena. Important: if Itam 27 is marked other than "natural; or then any Injury or other traumatic avant, the Medical and any 1 Never Merried 2 Merried Baitimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: p 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 5+ College (1-4or 5+) Elementary/Secondary (0-12) Research Physician Health Research 17 Father's Neme (First Middle Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) Virgil Bryant Scott Margaret Alena Smith 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10122 Hyla Brook Rd., Columbia, MD 21044-1705 Virginia S. Johnson/Daughter 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Jan Dele 9 20c. Location - City or Town, State 1 XBurial 2 Cremetion 3 Removel from Stete Pine Grove Cemetery 1999 4 ☐ Donation 5 ☐ Other (Specify) Parkton, MD 21. Signeture of Fugerel Seguce Dennise 22. Name and Address of Fecility J.J. Hartenstein Mortuary, Inc. 23a. Per Venter the disease, or complications that caused the deeth. Do not enler the mode of dying, such as cardiac or respiratory errest, shock or hear feiture. List only one cause on each line.

24 Second St., New Freedom, PA 17349

Approximately appr Approximele Intervel Between Onset end Death Physician Cerebrovaecular Recident Immediate Cause (Finel disease or condition resulting in death) Medical 20 Months Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vitai Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Failure Heart 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy lindings available prior to completion of cause of death? brillation 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 Tyes 2 No or Attanding Physician: 25. Wes case referred to medical examiner? 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this To the Phephyl or Attending Phivithin 24 hours afterdeath.
To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. tnjury et Work? 1 Neturat
2 Accident 5 Pending investigation 1 Yes 2 No 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide edical 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Dele signed (Month, Day, Year) D0052940 JAN 0699 LOW MID 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)
SANTAY P. SHAH, ND 10805 HICKORY Ridge Nd #210, Columbia, MD 21044

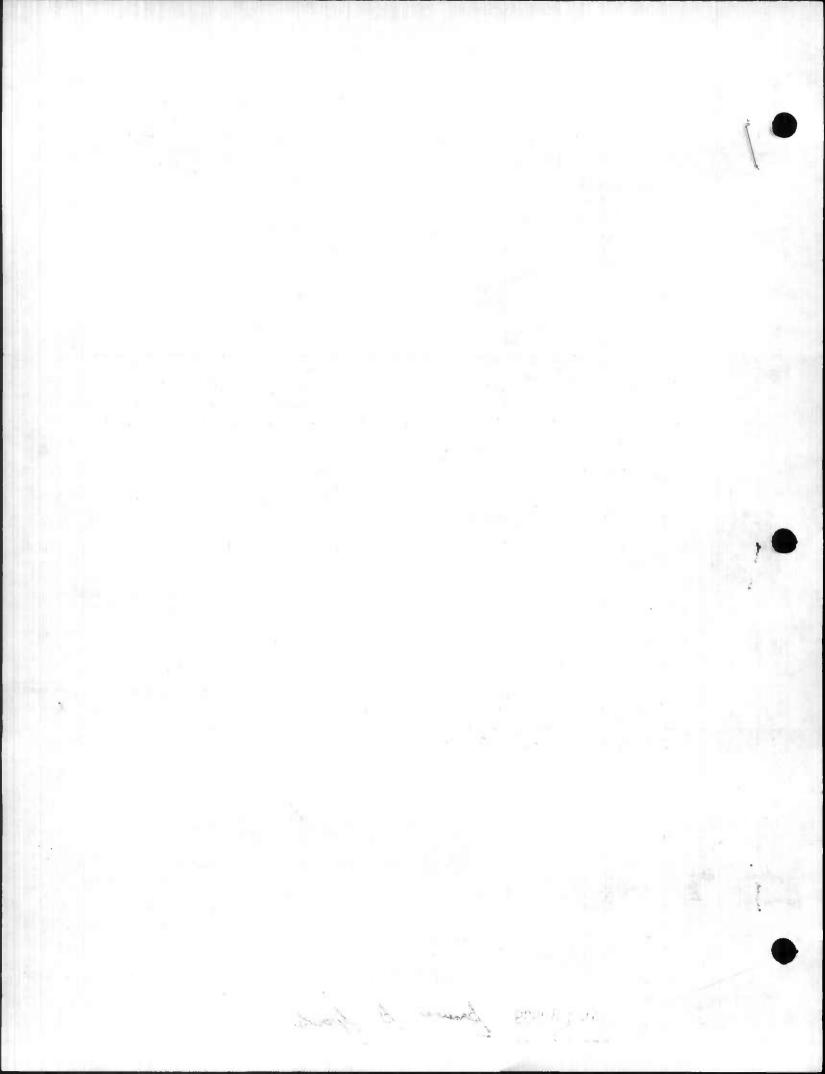
Registrar **DHMH 16 Rev 6/95** 

State

31. Date filed (Month, Day, Year)

JAN 1 3 1999

32. Registrar's Signeture



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 12rie Karda 11,1999 9:10 AM Januar 4a. Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death c. County of Deeth Seriatrics (e) + N/A Baltimore if Under 24 Hrs. 8. Date of 5. Sociel Security Number 224-07-5729 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Months Days Min. 1 M 2 XF Hours 11-6-19 VA Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Rosedale 1 Yes 2 No 10f. Zip Code 21237 10e. Street end Number 8116 Woodhaven Rd. 10g. Citizen of What Country? 12. Wes Decedent Ever in U,S. Armed Forces? Rece - American Indian, Black, White, etc. 11. Meritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Mercy Hospital Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Blaha Josephine Kratovil 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Miller / daughter 1807 Philadelphia Rd. Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest V.A. 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1X Burial 2 Cremation 3 Removal from Stete 4 Donation 5 Other (Specify) 1-19-99 Owings Mills, MD 21. Signature of Figure 1 Service Licenti 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237 MIAC 23a. Part1. Enter the disease, or complications that caused the death shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death Do not enter the mode of dying, such as cardiac or respiretory arrest, Immediate Cause (Final disease or condition resulting in death) . Abdomina Aortic Aneurysm Rupture Due to (or as a consequence of): arten DISCARE Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) d Cardiomyopath Hipertension 1ex Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. SIPAAA repair and a portoble moval by Pass HO My ocardial infanction, Diabete Mellitus, 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an eutopsy performed? Atrial Fibrillation, gastritis, COPD, paradegia Secondary to Spiral Coval infarction, Savral Luicev 25. Was case referred to medical exeminer? 1 Yes 2 No Hospital: 1 inpatient 2 ER/Outpetient 3 no Other: 1 in inpatient 2 in inpatient 2 in inpatient 2 in inpatient 2 in inpatient 3 no other: 1 in inpatient 2 in inpatient 2 in inpatient 2 in inpatient 2 in inpatient 3 in inpatient 2 in inpatient 2 in inpatient 2 in inpatient 3 in inpatient 3 in inpatient 2 in inpatient 3 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of injury 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificete be executed Box 68760, Division of Vital Records, P.O. Attending Physician: To the Hospital or Attendil within 24 hours efter death. To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

28a-f show

6 238 Director

Funeral

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Completed

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Physician/Medical

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Certification: To

Medical

traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours efter deeth and Mental Hygiene. Is marked other than "natural", or Items 23.

permit. Peges 1 end 2 sh Department of Health and Important: If Itam 27 ia m any Injury or other traum once.

**Physician** /Medicai

Examiner

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certificate

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After

death.

funeral director,

Baltimore, Maryland 21215-0020

the Meryland

31. Date filed (Month, Dey, Year) State Registrar

29a. Certifier (Check only one)

\*\*Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and menner as steted.

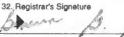
2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) and menner stated. 29b. Signature and title of certifier

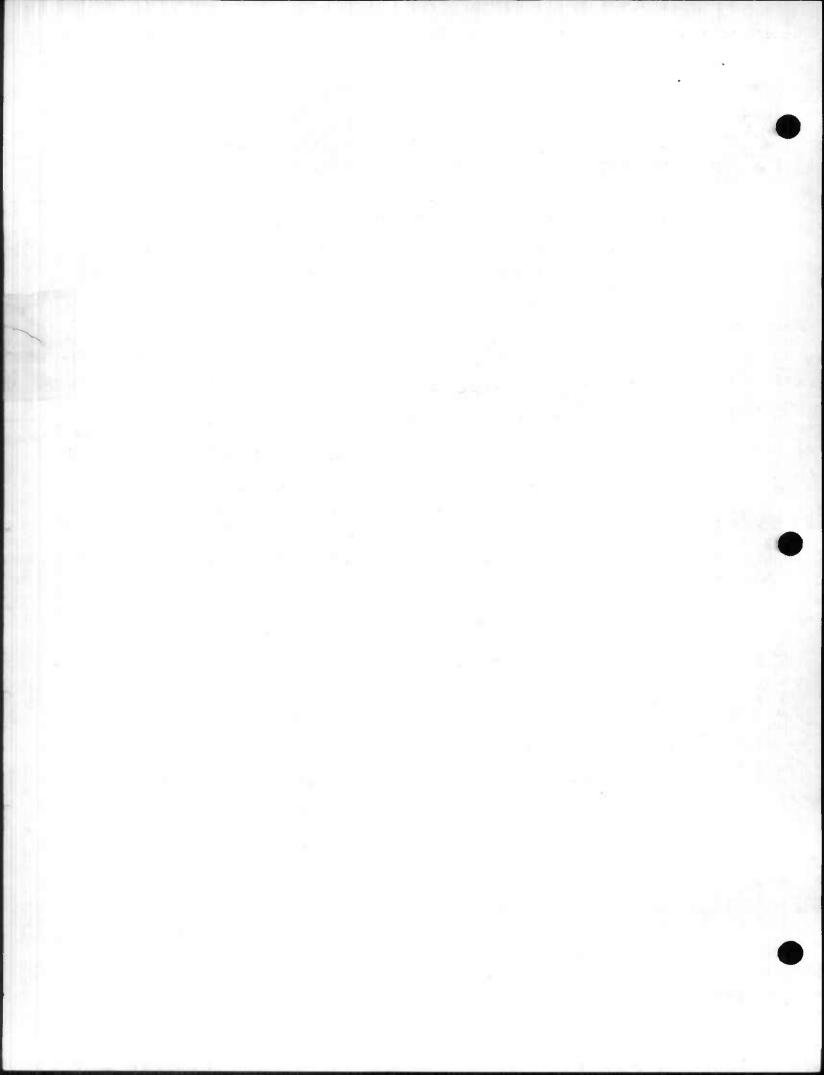
29c. License number

29d. Date signed (Month, Day, Year)

Janucer eted cause of death (Item 23a) (Type, Print) 550 5 Hop Lines Dyvas 30. Name and address of person who come B. Oree nou MD BaIT M hin

JAN 1 3 1999





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev Year 07, 1999 4c. County of Death Elizabeth May Smith 4b. City, Town, or Location of Death 3:00 AM 4e Facility Name (If not institution, give street and number) Elkridge
If Under 24 Hrs. 8.
Hours | Min. 6113 Hunt Club Road Howard Co. If Under 1 Year 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 1 DM 2 DF Deys Months 220-46-4020 November 01,59 Baltimore, Md 10c. City, Town or Location 10d. inside City Limits 10e State 10h County 1 ☐ Yes 2 ☑ No Maryland Howard Co. Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6113 Hunt Club Road 21075 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian. 11. Merital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dales: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Artist Stain Glass Art 12 01 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James William Johnson, III Anne Dorothea Pfeil 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Mr. Andrew Row Smith, Jr. (Husband) 6113 Hunt Club Road Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burlat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 01/11/99 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Peral Service Licensee alr 1050 York Rd. Towson, Md. 21204 1. Effer the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, as k, or heartfailure. List only one ceuse on each type. Approximate Interval Between Onset and Death Squamous Cell Carcinoma of Cernx + Vagina Immediate Ceuse (Final disease or condition resulting in death) ~ lyear Short Bowel Syndrome Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Recurrent Small Bowel Obstructurs Due to (or as a consequence of): Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? Retroperatoreal fibrosarcoma (1980) Stechemo. 1□ Yes 2□ No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Was en autopsy performed? + radiation therapy. SIP total pelvic exenteration 10/98 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medicel examiner?
1 Pres 2 No 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injun 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner Division of Vital Records, P.O. Box 68760 that the deeth certificate be Attending Physician:

physician end the burial-transit 98 for use es signed by the a certificata has t lirector, pege 2 s After or Attend efter death Director: A To the Hospital or within 24 hours eff To the Funeral DI completely filled in

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f ahow

"natural", or items 23s or

nd 2 should be filed within 72 hou alth and Mental Hygiena. 27 is marked other than "natural r treumstic event, tre Medical E.

permit. Peges 1 and 2 should be file Department of Health and Mental Hy, Important: If fem 27 is marked othe any Injury or other treumatic event, pince.

**Physician** 

/Medical

Examiner

Physician/Medicai

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Certification: To

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29a. Certifier

(Check only one)

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Funeral

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death

72 hours after

altimore, Maryland 21215-0020

Registrar

State

290. Signature and title of cellifier Deputy ME MD

29c. License number

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) Jan 11, 1999

30. Name and address of person who comp ted ceuse of death (Item 23a) (Type, Print)

Come Way Ellicot City MD 21042 PATRYCE A-TOYE, MD 4565 Hemlock

31. Date tiled (Month, Day, Year) 32. Registrar's Signature JAN 1 3 1999

THE R. P. LEWIS CO., LANSING, MICH. The first specific to a first section Symmet C. D. C. man of Corner & Vagina Apply to Maple awarang Literahawa Received Found Board Chestronehins and to con I have some I have myed it siving large 413 provide milespec + 690 miles YELL -tookson S. Y. S. C. Inmost and pl Any Sol experience in the secretary law were law was I have a little and

**Physician** /Medical Examiner

certificete be executed

Box 68760

Division of Vital Records.

Depertment of Important: If eny injury or page.

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

**Funeral** 

Director

7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours efter of neat of Heelih and Mental hygiano.
ant: if Item 27 is marked other than "naturel", or item into or other traumatic event, the Medical Examinar inty or other traumatic event, the Medical Examina

Maryland 21215-0020

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Examiner physicien end Physician/Medical 80 esn signed t þ Completed hes certificete funeral director, Be 20 this Certification: is or Attending P safter death.

I Director: After t d in by the funers

25. Wes case reterred to medicat 1 ☐ Yes a☐ No 27. Manner of Death Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Yeer) 28c. tnjury at Work? 1/2 Natural 5 Pending investigation 1 Yes 2 No

26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of ceut

6 Could not be

29c. License number

29d. Date signed (Month, Day, Year)

28t. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print) Charles ST 6569

State Registrar

edicai

31. Date tiled (Month, Dey, Year) JAN 1 3 1999

3 ☐ Suicide

29a. Certifier (Check only one)

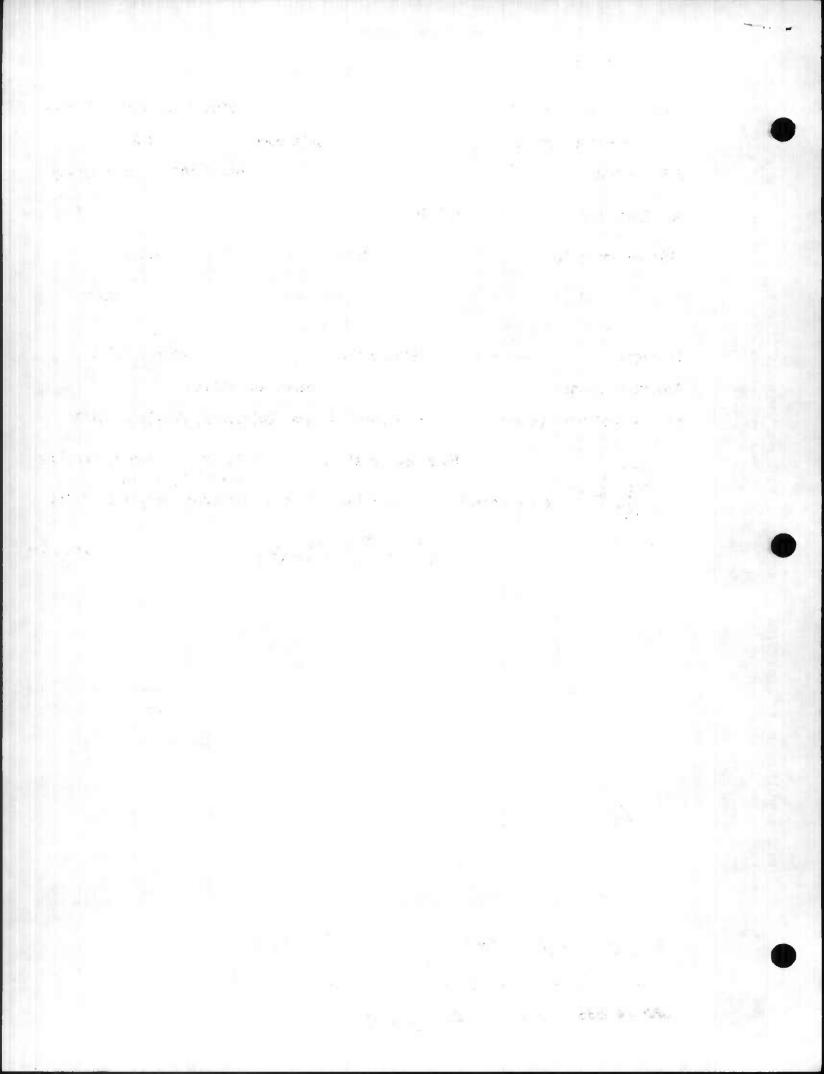
4 Homicide

32. Registrar's Signature

28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)

**DHMH 16 Ray 6/95** 

To the Hospital within 24 hours To the Funeral I completely filled



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Phys /Me	ician dical	17 11 12			Schwa	artz			Month Januar	Dey 09,	Yeer 1999	3:10 AM			
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		Riverview						Baltim			timore				
。Funer Directo		5. Sociel Security Number 212 09 5612 Usual Residence of Dece		Sex 1□M 2☐F	7. Age (In yr	s. lest birthde 4 Yrs.	Months Deys		8. Dete of Birt (Month, Da Sept 1	1914	9. Birthpl Count Mary	ece (Stete or Foreign lry) land			
yland		10e. Stete 10b. County 10c. City, Town or Location								10d. Inside City Limit					
e Mar	ctor	Maryland Baltimore Essex								1 ☐ Yes 3人 No					
ath with th	rai Director	10e. Street end Number  1 B1					10f. Zip Code	21221		10g. Citizen of USA	Whet Count	try?			
d within 72 hours after death with the Manyland glane. glane. The Medical Examiner chart be notified at	by Funeral	3€ Widowed 4 □ D	11. Marital Status  1 □ Never Married 2 □ Marrled  3 ☑ Widowed 4 □ Divorced  12. Wes Decedent Armed Forces?  1 □ Yes 2 □ If Yes, Give X Yeer or Detes:			U,S. 13	. Wes Decedent of If Yes, specify Cut	Hispenic Origin? (Speen, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Rei Bie Specif	ce - America ck, White, e	etc.			
thin 72 ho	Completed	15. Decede (Specify only high		ducation ade completed)		16e. Dec	edent's Usuel Occu	cupetion ne during most of working tired)		16b. Kind of B	ustry				
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be filed with ntal Hygiane. od other than	ပိ	17. Fether's Name (First,	10 Fether's Name (First, Middle, Lest)			DI	ectan	18. Mother's Nem	e (First, Middle	School irst, Middle, Meiden Sumeme)					
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nd 2 shoulth end 27 is m	-	19e. Informent's Neme/Re Lynda T. War			hter)	19b. Mai 210	ling Address (Stree	t end Number or Rui	ral Route Number	r, City or Town ryland	Stete, Zip 21221	Code)			
bemit. Pagas 1 el popartment of Heal mportant: if item in in injury or othe		20e. Method of Disposition  1 □ Buriel 2  Crer  4 □ Donetion 5 □ C	netion 3 [		Stete Gr	Piece of Disp cemetery, cr	position (Name of emetory or other ple nt Cremat	oce)	Dete 1/1999	20c. Location	•				
pemit. Pagas Department of Important: If i	Suce.	21. Signature of Funeral S		-	1	В	22. Name and Addy TuŽďŽINSK	i Funeral Lastern Av	Home P		rylan	d 21221			
N 10 10		23a. (art 1 Inter the dise	ese, or con	plications that c	aused the de	1		Ing, such es cardiec		-	T	Approximate			
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rificate be executed og physician end as the buriel-transit	edical Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death I set													
	n/Med	resulting In deeth) Lest  Due to (or es a consequenca or):  d.													
death	sicia	Pert II. Other significant of	onditions o	contributing to de	eth but not re	suiting in the	underlying cause gi	ven in Pert i.	23b. Did t	obacco use co	ntribute to	the cause of death			
res that the derigned by the e	by Physician/M	Dementia							res 2□ No 3□ Probably 1 nknow						
aw requi	Completed								24e. Wes o		com	re autopsy findings lieble prior to apletion of cause eeth?			
To the Hospital or Attending Physician: The I within 24 hours aftar death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, pega	Com								1 🗆 Y	es 20 No	10	Yes 2 No			
	å	25. Wes case referred to rexeminer?	nedicai					28. Plece of Deet	h (Check only or	18)					
or Attending Physician: Tafar death. Director: Affer this certificat	5										)				
Ming P	lon	27. Menaer of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury Work?							28d. Describe h	ow Injury occur	red				
or Attending Physician: after death. Director: After this certific In by the funeral director,	Certification:	2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide  Investigation Could not be determined  28e. Pleca of Injury - At home, ferm, street, featuring, etc. (Specify)						Yes 2□No	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
spita ours nerai	edicai C										ited. the cause(s)				
P Fur	Me	29b. Signeture equal 1	certifier		MO		29c. Liceo	se number 5 7	91 3	9d. Date signe	d (Month, D	ley, Yeer)			
To the Hospital or within 24 hours after To the Funeral Dir completely filled in		· rec	n	/	119	,	J	, 0,55	/ /	1 -	10-	1999			
To the Hor within 24 h To the Fur completely		30. Name and address of p	ersen who	completed cause	e of deeth (ite	m 23e) (Type	Print) Wen	Blid, a	91 Baltin	nove M	23	1999			

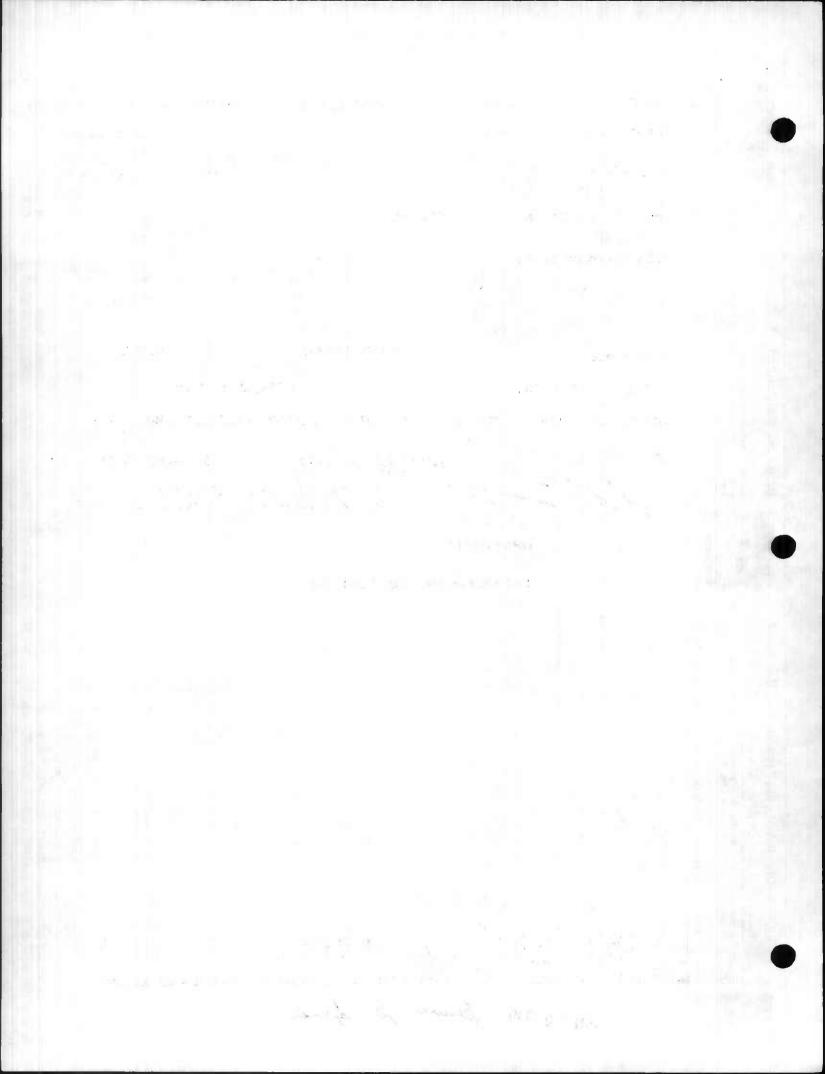
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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle Lest) Month JANUARY Physician JUANITA ANNABELLE SCHWEITZER 07, 1999 9:25 FM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Eacility Name (ILnot institution, give street and number)
Saint Joseph Medical Center Examiner Towson Baltimore If Undar 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Steta or Foreign Country) **Funeral** Deys Hours 1 M 2 F 219-20-5414 Yrs 11/13/26 Director MARYLAND Usuel Residence of Decedent r 25a-f show inotified at 10a. Stete 10b. County 10c. City, Town or Location 10d. inslda City Limits The Maryla 1 ☐ Yas 2 1 No MD BALTIMORE HILLENDALE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 6 the Medical Examiner must be 21234 USA 'natural', or Items 23s 1213 Linkside Drive Funeral 14. Race - Amarican indien, Bleck, White, etc. 12. Wes Decedant Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus filed within 72 hours after 1 ☐ Yes 2X No If Yas, Give Yeer or Detes: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 Yas 2 KNo Specify: g 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) OFFICE WORKER **INSURANCE** 12th Grade 18. Mother's Nama (First, Middle, Meiden Sumame) 17. Fathar's Nema (First, Middle, Last) 1 and 2 should be Mental marked BEATRICE V. KEYS HOWARD V. PYLE, SR. 2 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Department of Health ar Important: If Nem 27 is ROBERT SCHWEITZER HUSBAND 1213 LINKSIDE DRIVE BALTIMORE, MD 21234 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a Mathod of Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) CEDAR HILL CEMETERY 1/12/99 BROOKLYN PARK, MD 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Enter the decrease, or complications that caused the deeth. Do not en for heart failure. List only one cause on sech line. Approximata Interval Between Onset end Deeth Physician ARRYTHMIA Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Due to (or es e consaquance of) INTRACRANIAL CONTUSTION Examiner attending physician and I for usa as the bunal-transit certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseesa or Injury that initiated exacts) Due to (or es e consequence of): Box 68760 Physician/Medicai thet initiated evants resulting in deeth) Lest Dua to (or as a consequence of): requires that the death 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. P.O. the th signed by 1 Yes 3 Probably 4 Unknown g Records, 8 24b. Were eutopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? Deed certificata has b The law paga 23 NO Division of Vital Physician: 25. Wes case referred to madical axaminer? Be 26. Plece of Death (Check only ona) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 inpatient 2 ER/Outpatient 3 DOA After this funeral Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Certification: or Attending 1 Neturel 5 Panding investigation 1 Ves 2 No death. Director: / 2 Accidant 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 6 Could not be 3 Suicida 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) after 4 D Homleide To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledga, deeth occurred at the time, date and piece, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a, Certifier 29b. Signature 29c. License number 29d. Dete slaned (Month, Dev. Year) 30. Neme end eddress of person who completed causa of death (Itam 23a) (Type, Print) WALTER B. KOPPEL, M. D. , 7620 YORK ROAD TOWSON, MARYLAND 21204 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State Registra



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** January Mary E. Scott 4c. County of Death 6:03 PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) Examiner Glen Burnie Hos O i tral

7. Age (In yrs. last birthday) Anne Arundel North Arundel If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (Stata or Foreign 6 Sax **Funeral** Months Days 1□M 2X F 214 26 4326 68 Yrs. Director Maryland Usual Residence of Decedent 10a Stata 10b County 10c. City, Town or Location r 28a-f show 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Anne Arundel Glen Burnie Directo 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21060 304 Marie Avenue U.S. "natural", or flams 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: ģ White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11th 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middle, Last) Be Department of Health and Mental important: If New 27 is marked of (not available) (not available) Bozeman Elizabeth 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 304 Marie Avenue Glen Burnie, Maryland 21060 Paul Scott 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, Stata 1 St Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial Park 1/11/99 Glen Burnie, Maryland 21. Signatura of Funeral Service Licensee 22. Nama and Addrass of Facility Gonce Funeral Home P.A. manuour 4001 Ritchie Highway Baltimore, Md. 21225 lu Part I. Enter the disorder, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death Physician myocarded inforction /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting Due to (or as a consequence of) Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 987 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t, 14 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1 Yas 20 No 1 Yas 2₽ No To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; I 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27 Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At homa, larm, street, lactory, office building, alc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to tha cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) Jan 8, 1999 D23624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 S- Crain Highway, Glen Burnic mg 21011 K. KHANDELWAZ BASANS 31. Data filed (Month, Day, Year) JAN 131999 32. Registrar's Signatura State Registrar

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Box 68760,

Division of Vitai Records, P.O.

Scott,

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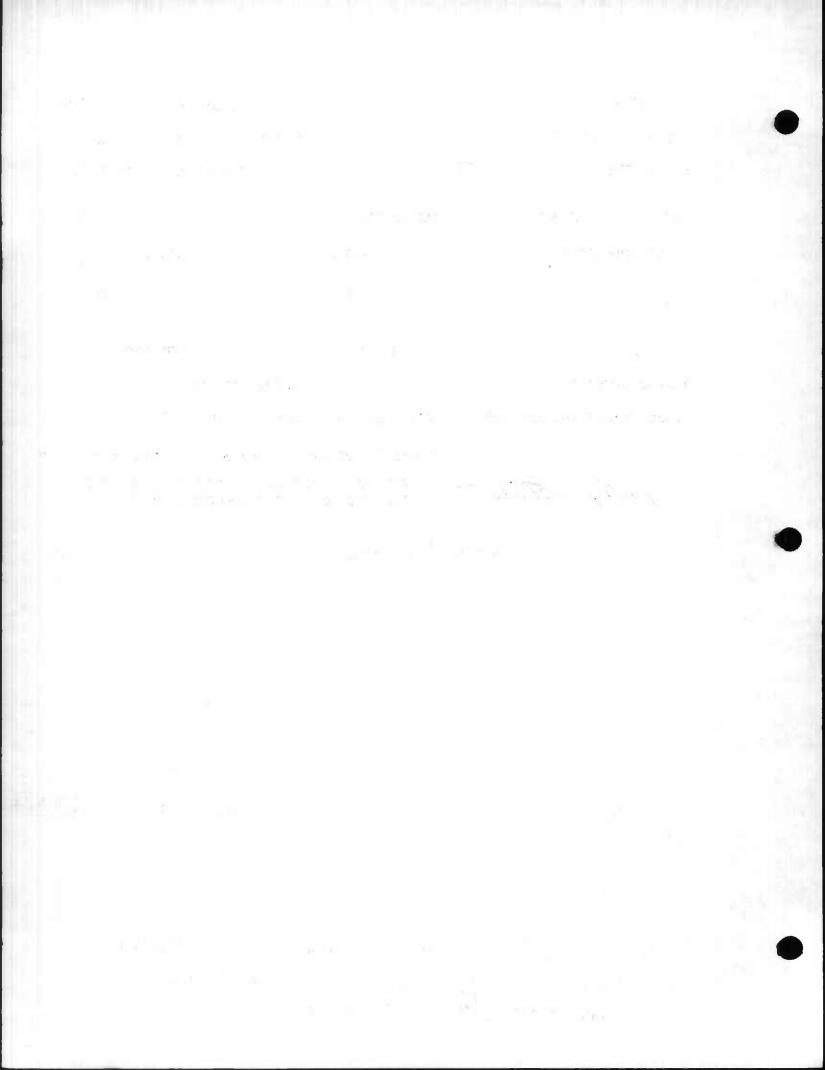
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** EDNA THOMAS 5:00PM JANUARY 5, 1999 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 5523 MOORE STREET BALTIMORE ANNE ARUNDEL 5. Social Security Number 7. Age (In vrs. lest birthday) If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funerai** 1 □ M 2 🗓 F Months Deys Hours Min 70 Director 415-38-7224 TENNESSEE 11/04/1928 Usual Residence of Decedent deeth with the Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-1 shore the Medical Examiner must be notified at 1 Yes 2 □ No Director MONROE BEALLSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 52244 WEST DRIVE 43716 Funerai U.S.A. 11 Marital Status 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 2 should be filled within 72 hours effer and Mental Hygiene.
Is marked other than "natural" or Ital 1 Never Married 2 Married ☐ Yes 2 No Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: WHITE þ 3

Widowed 4 □ Divorced Yeer or Detes: Completed 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 HOMEMAKER OWN HOME other traumatic event, 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Pages 1 end 2 should 2 THOMAS BRADFORD VALLIE NICHOLS 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) item 27 l YVONNE THOMAS-LUTZ/DAUGHTER 5523 MOORE ST. BALTIMORE, MD 21225 20e. Method of Disposition 20b. Place of Disposition (Neme of 20c. Location - City or Town, State permit. Pages Department of H Important: If ite any Injury or of once. cemetery, cremetory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BEALLSVILLE CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 1/9/99 BEALLSVILLE, OH of Funeral Service Licenses 22. Name end Address of Fecility STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. ach 23e. Perf.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 736 EDMONDSON AVE.CATONSVILLE, MD 21228 Approximete Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest and Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, ettending physicials The law requires that the deeth certificate be the Due to (or as e consequence of) 80 USB 6 for Pert II. Other significent conditione contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the detached 2 No 3 Probably 4 Unknown Completed by 8 24b. Were eutopsy findings evallable prior to completion of cause of deeth? should 24a. Wes en eutopsy page 2 1 Yes ZON 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: 1 within 24 hours effer death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) DAUGHTER' Other: 4 Nursing Home Residence 6 Other (Specify) RESIDENCE Hospitel: 2 1 ☐ Yes E5 (10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation Netural 2 Accident 1 Tes 2 No 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide 29a, Certifier Medical Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) ive 415 Owings Mills MD21117 Dey, Year 32. Registra 's Signeture State 1 3 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#20b perFHG767 1/21/99 EW 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Janua 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) **Examiner** ve Da more If Under 24 Hrs. If Under 1 Year ice (State or Foreign 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** Days Hours Min. 34-4470 1 M 2 F Yrs ano Director Usual Residence of Decedent death with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Director Maryland more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or a page. 2120 a Funeral 14. Race - American Indien. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Bleck, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black Specify: by 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Friend) Montfo llam Balto, Md. 20b. Place of Disposition (Name of cometery, crematory or other place)

Voshell Mem. Bardens Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 Burlal 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name end Address of Facility L. Russ Funeral Home W. North Ave. Balto, Md. the distance, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, or near tallars. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner ss been signed by the attending physician and 2 should be detached for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Division of Vital Records, P.O. Box 68760 Up un Due to (or as a consequenca of). 23h. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed Director: After this certificate hes 2 NNO 1 ☐ Yes 2 ☐ No 1 Yes Physician: the funeral director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? Certification: al or Attending F s after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 □ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a. Certifier completely

State Registrar 31. Date filed (Month, Day, Year) 1999

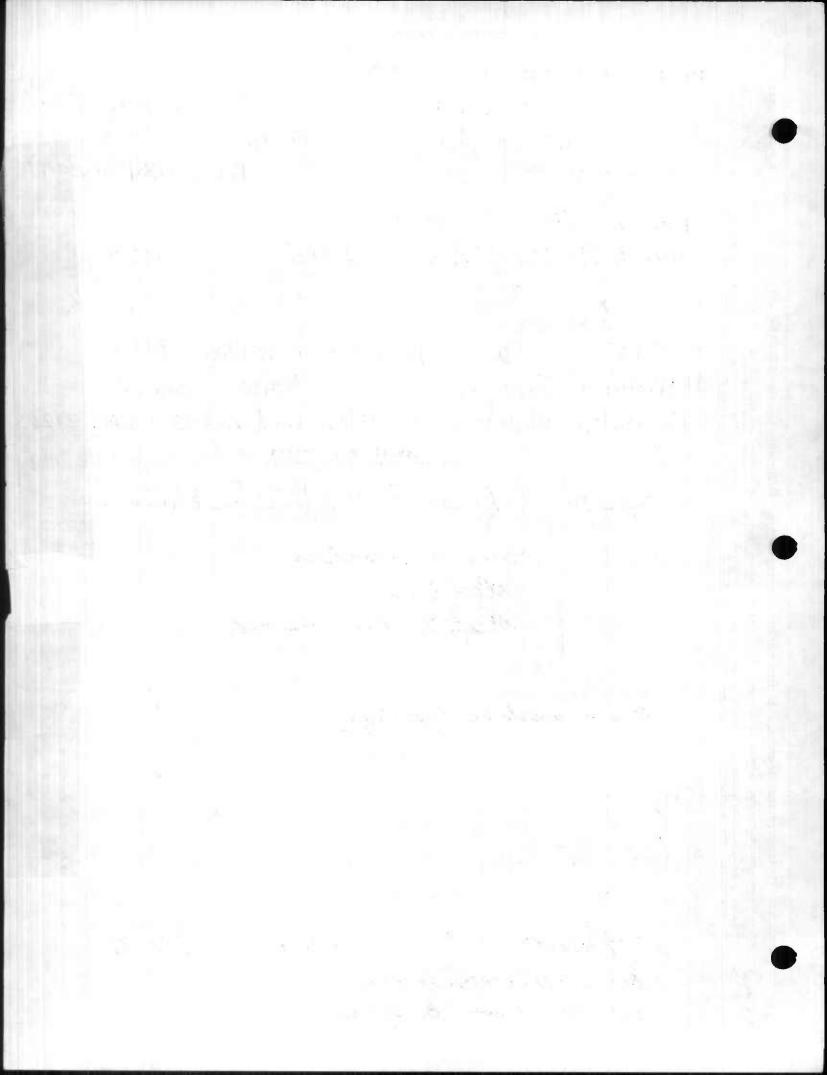
29b. Signature and title of cartifier

ROSLE 32. Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

29c. License number D1610

29d. Date signed (Month, Day, Year)



#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month **Physician** Janice Tickle 1999 anuary /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death Examiner Square Baltimore solta PR edale ff Under 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 25, 1 9. Birthplaca (Stata or Foreign Country) North Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 K Yrs Director 216 36 6525 58 Usual Rasidence of Dacedant 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Director Maryland Baltimore Rosedale 10e. Street end Number 10f. Zio Code 10o. Citizen of What Country? 1013 Sumter Avenue 21237 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ∑No If Yas, Giva Yaar or Detas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 14. Race - Amarican Indian, Black, Whita, etc. 1 Never Married 2 M Married 1 ☐ Yas 2 DtNo Specify: p Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) Elemantary/Secondary (0-12) Coilega (1-4or 5+) Homemaker Own Home 17. Father's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middle, Meiden Sumeme) Be Talmadge Joseph Cavdill Alda Victoria Osborne 0 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald E. Tickle Sr. (husband) 1013 Sumter Avenue Baltimore Maryland 21237 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Holly Hill Mem. Gardens 1/14/99 Baltimore County Md 21. Sig ure of Fullet 22. Name and Address of Fecility Bruzdzinski Funeral Home PA 1407 Old Eastern avenue Essex. Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical 2 Months Examiner RonaR Sequentially tist conditions, if any, leading to immadiata cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in daeth) Last Due to (or as a consequenca of) Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No p 24b. Ware autopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No 25. Wes casa rafarred to medical Be 26. Placa of Deeth (Check only one) Hospitat: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) To 1 Yas 210 No 27. Manner of Death 28a. Data of tnjury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending invastigation 1 Yas 2 No 2 Accidant 6 Could not be datamined 3 Suicide 28e. Piece of Injury - At homa, tarm, street, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicida edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, deta and place, end due to the cause(s) and manner as stated. | Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Cartifian

certificate be exec P.O. Box 68760, Records, Division of Vital Attending To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: A completely filled in by the fu

Hem 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Madicial Examinar must be notified at

Department of Health and Mental Hygiene. Important: If tem 27 is marked other than any injury or other manner.

ettending physician and for use as the buriel-trans

signed by the e

peen

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After this

death.

Pages 1 and 2 should be finent of Health end Mental i

altimore,

the Maryla

Registrar **DHMH 16 Rev 6/95** 

State

(Check only one)

30. Nama and address

29b. Signatura and titla of certifiar

31. Data filed (Month, Dey stra s Signetura 32 Reg 1999

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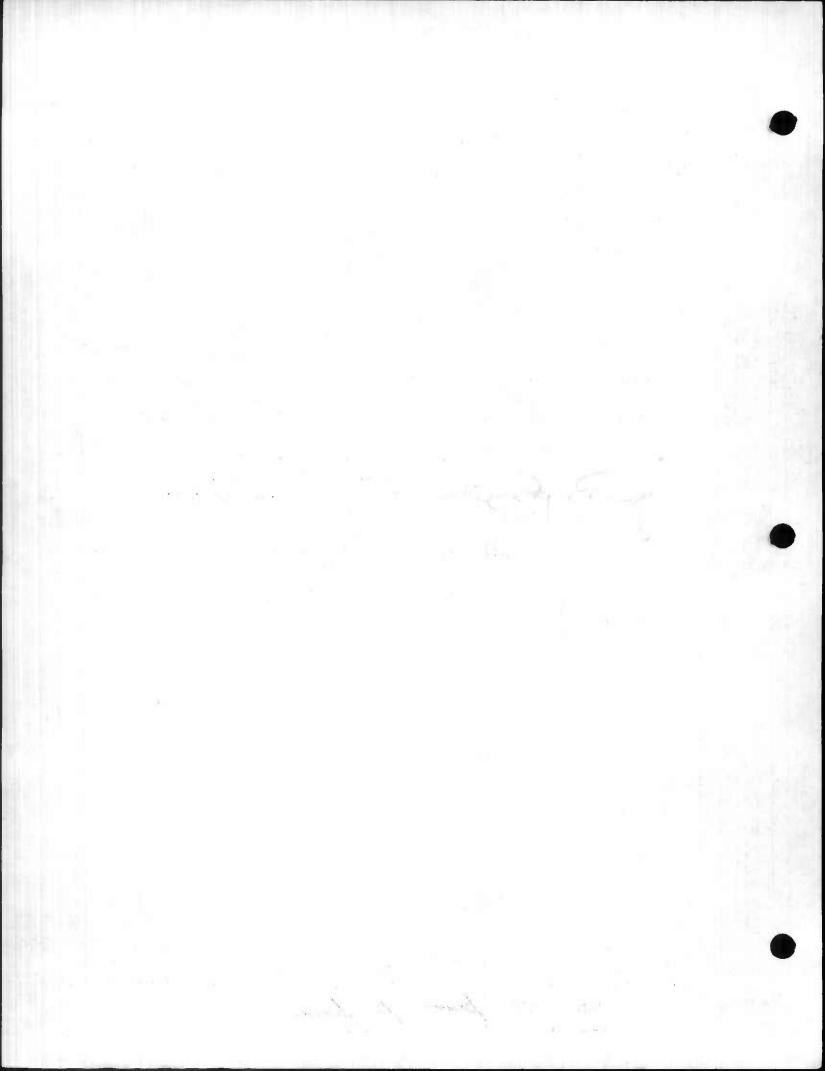
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pleted cause of acath (from 23a) (Type, Print)

Drive Baltimore, MD 21237 9000 Franklin

29c. Licansa number

29d. Data signed (Month, Day, Year)



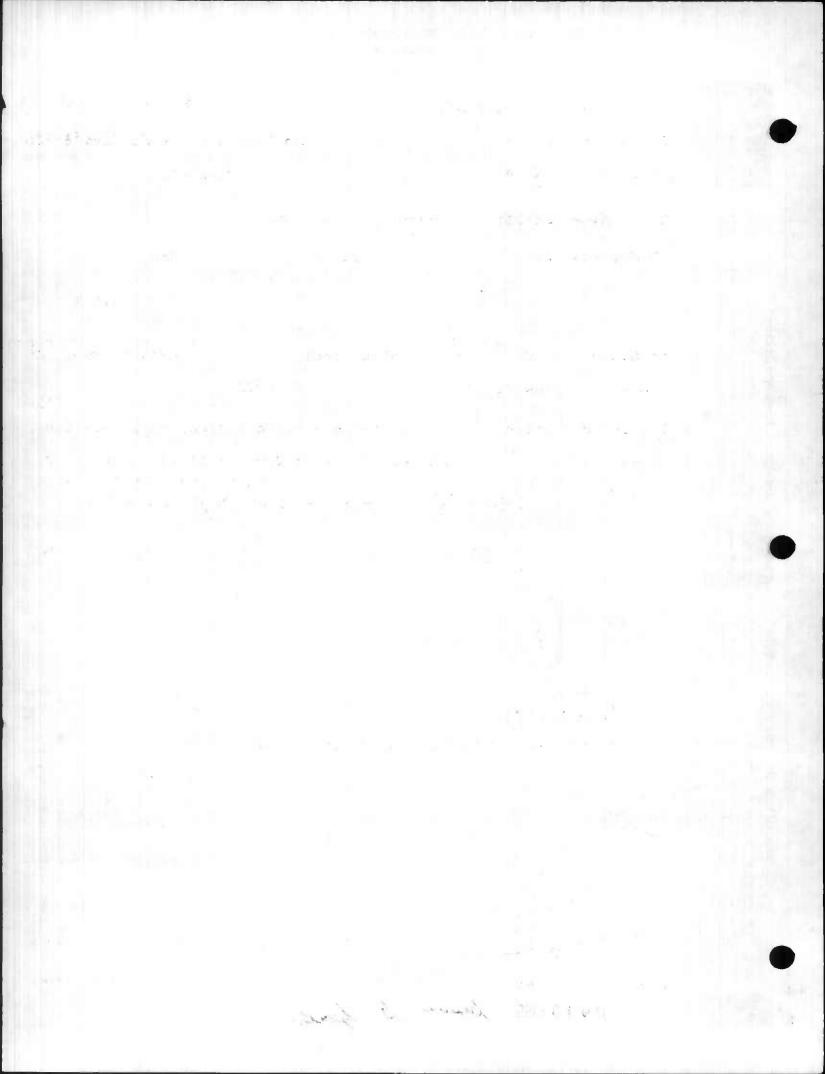
## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** XIS AM 99 Ernestine L. Warrenton /Medical 4a Facility Name (If not Institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Severna Park 109 Metispa Drive Magothy Bridge 7. Age (In yrs. last birthday) if Under 1 Year if Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 25 F Yrs. 219-22-9155 78 PA 02-28-20 **Director** Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinal maint be notified at 1 ☐ Yes 2 ☐ No Severna Park Magothy Bridge-DDU Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 109 Metispa Drive 21146 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 72 hours after 1 ☐ Yes 2€No If Yes, Give Year or Dates: 1 Never Married 28 Married "natural", or 1 ☐ Yes XXNo Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Store Hygiene. 9th Grade Sales Clerk K-Marts Dept. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) i 2 should be fi h end Mentel H is marked of James Stewart Claudia 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21146 19e. Informent's Neme/Reletionship (Type, Print) Pages 1 and 2 sinent of Health en 109 Metispa Drive Severna Park, Maryland
of Disposition (Name of Date 20c. Location - City or Town, State other Ferris Warrenton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Buriel 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) MD. Nat'l Mem.Pk.Cem. 01-14-99 Laurel, MD. 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tellure. List only one cause on each line. 1101 E. North Approximate Interval Between Onset end Deeth **Physician** Immediete Ceuse (Finel diseese or condition resulting In death) 5 YEARS /Medical EMPHYSEMA **Examiner** Due to (or as e consequence of) Physician/Medical Examiner ettending physician and for use es the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 certificate be Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed by the e 23b. Did tobasco use contribute to the cause of death? P.O. signed by the 12 Yes 2 No 3 Probably 4 Unknown DEMENTIA Records, þ 24b. Were eutopsy findings aveileble prior to completion of cause of death? ARTGRIOSCUPRETTIC CARDIOVASCULAR Completed 24e. Wes an autopsy performed? peen The law certificate has 1 ☐ Yes 2 No 1 Yes 2 HNG Division of Vital Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Thesidenca 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 10 1 Yes 2 No After this 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred Certification: in Hospital or Attending in 24 hours efter deeth.
The Funeral Director: Aft 1 ENature 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 29a. Certifier edical To the Mosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end pleca, and due to the cause(s) and menner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 21776 Unde JANUARY 7 NO 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) SURYA MUNDRAMO RITCHIE HWY PARADENA MOZIE 8109 31. Date tiled (Month, Dey, Year)

JAN 1 3 1999 State

Registrar

32. Register's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** allace JANUARY 1999 11:00am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Undar 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) If Undar 1 Year 8. Data of Birth (Month, Day, 9. Birthplaca (State or Foreign Country)
Makyland **Funeral** Months 1 M 2 F **Director** Usual Rasidanca of Decedan 10a. Stata 10b. County 10c. City, Town or Location 28a-f show 10d. fnslde City Limits Department of Health and Mental Hygiena. mportant: if item 27 is marked other than "netural", or items 23a or 28a-f show any Injury or other traumstic event, one Modical Examinar must be notified at 1 ☐ Yes 2 No Director 10e, Straet and Number 10f. Zip Code 10g. Citizan of What Country? Funeral 12. Was Decedant Evar in U.S. Armad Forces? 13. Was Decadant of Hispanic Origin? (Spacify Yes or No-if Yas, specify Cuben, Mexican, Puarto Rican, atc.) 11 Marital Status 14. Raca - Amarican Indlen, Nilson Wallace Black, White, etc. 1 Navar Marriad 2 Marriad Yes 2 2 No 1 ☐ Yas 2 DENO Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorcad Year or Dates: Completed 16a. Dacedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Collaga (1-4or 5+) 10 17. Father's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Be 19e. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3626 Stanshul
20b. Place of Disposition (Name of Data 20a. Mathod of Disposition 20c. Location - City or Town, Stata cametery, cramatory or other place) 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licansac 22. Name and Address of Facility 23e. Parf1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death owen LOBE PNEUMONIA **Physician** /Medical Immediete Causa (Final disaasa or condition rasulting in deeth) Examiner BSTRUCTIVE LUNG DISERSE tha bunal-transit Saquantially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Diseesa or Injury that Initiated avents rasulting in daath) Last and Dua to (or as a consequence of) P.O. Box 68760. physician Physician/Medical Dua to (or es a consequança of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t A Yes 2 No 3 Probably 4 Unknown Records. by should 24b. Were eutopsy findings eveilebla prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physicien: within 24 hours efter death. To the Funeral Director: After this cartific. 25. Was casa referred to medical axaminar? 26. Pleca of Daath (Check only one) Hospital: Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) 1 Yes 2 No -+☐ Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Yeer) 28b. Time of Injury Certification: 28d. Describe how Injury occurred 28c. Injury et Work? Natural 5 Panding invastigation 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicida 6 Could not ba 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 Homicide Tip Certifying Phyalcian: To the best of my knowledga, death occurred at tha tima, date end plece, end dua to the causa(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end pleca, and dua to the causa(s) and menner stated. edicai 29a. Certifiai 29b. Signatura and titla of certific 29c. Licanse number 29d. Date signed (Month, Dey, Year) 30. Nama end address of person who completed causa of death (Item 23e) (Type, Print) In (1 RD PHOEPIX MP21131 NER HE

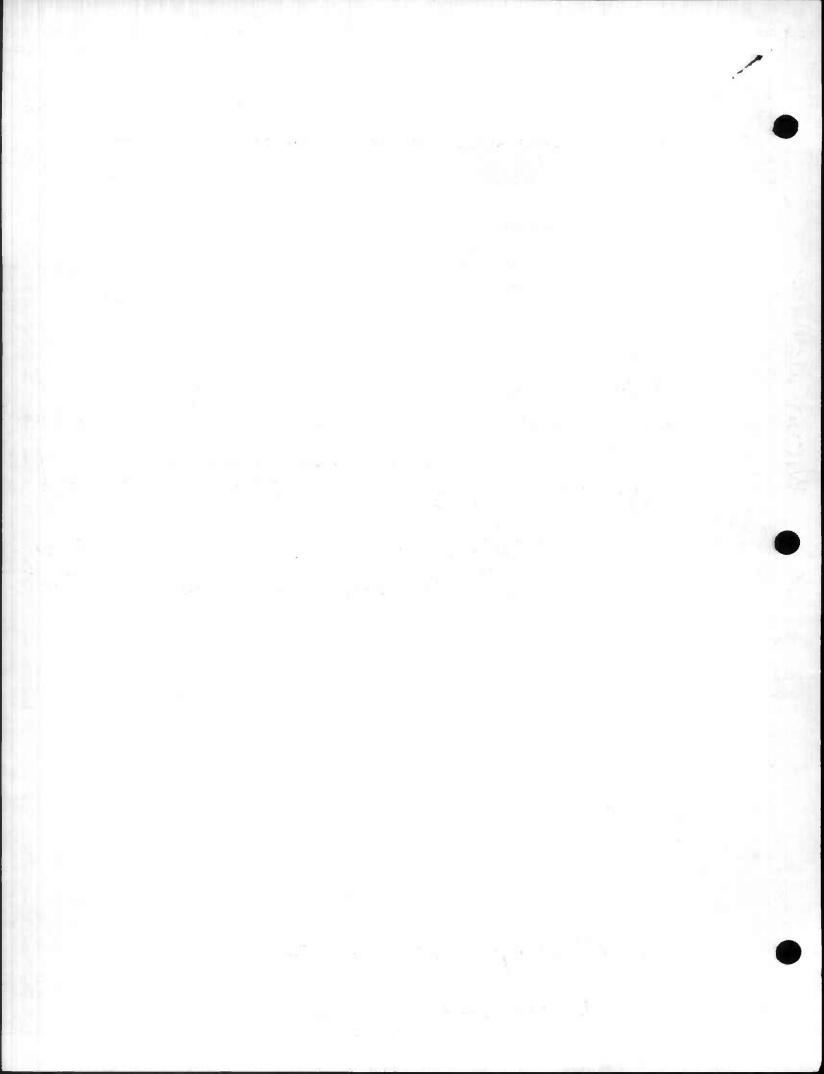
32. Ragistrar's Signature

JAN 1 3 1999

DHMH 16 Rev 6/95

State

Registrar



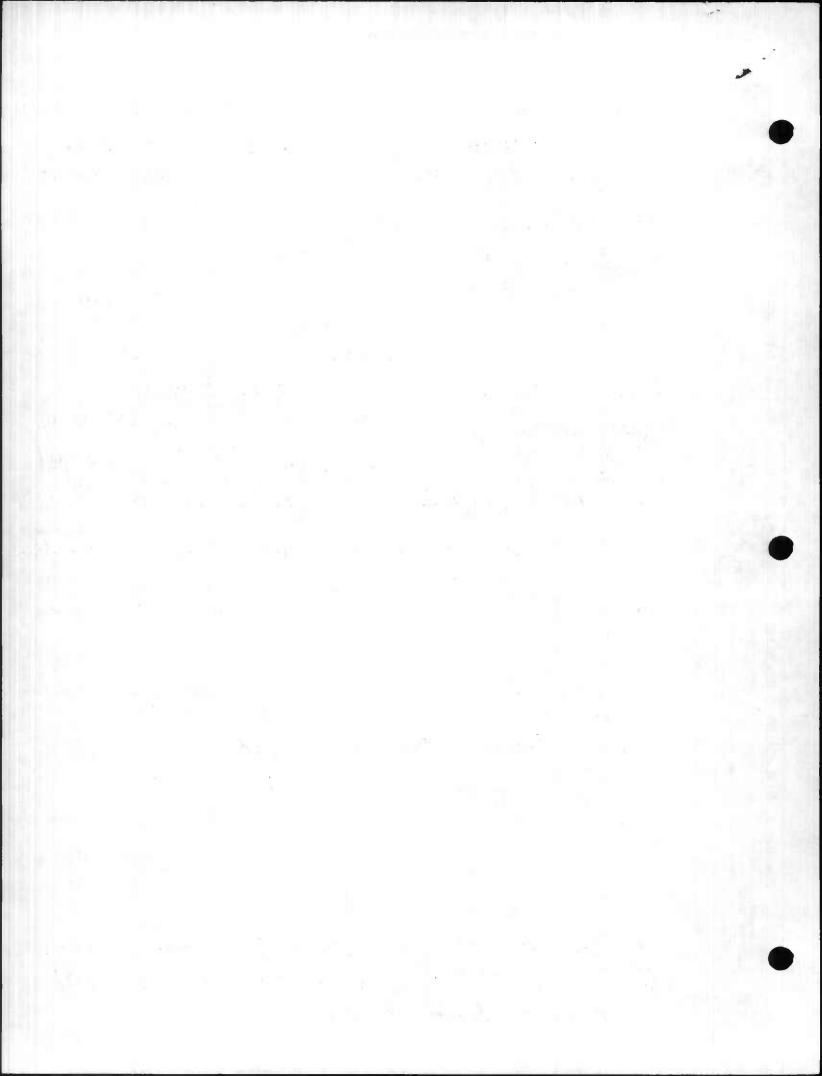
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Physician 10:00AH VIlliamson January /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign
 Country) **Funeral** Deys Min 1□ M 2/0 F Months Hours 219-20-758 Usuel Residence of Decedent 7 Yrs. Director ennsylvania 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director 101. Zip Code 10e. Street and Number 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 2826 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 25 No If Yes, Give Year or Dates: 11. Marital Status 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: White Baltimore, Maryland 21215-0020 Specify: 3 NWidowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind ot Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) 10 7 is marked other traumatic event, I permit. Pages 1 and 2 should be file. Department of Health and Mental Hy Important: If them 27 is marked other any injury or other traumetic event. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Fielationship (Type, Print) Md 2826, Calney 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State San. 13 1 ☐ Burlai 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses vans 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medicai Examiner 403 and I-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last physician at s the burial-t Division of Vital Records, P.O. Box 68760. Due to (or as a consequence ot): 80 ettending p signed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 21 No 3 Probably 4 Unknown 1 M p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy certificate has b 2 X No 1 Yes 1 □ Yes 2 □ No Hospital or Attending Physician: funeral director, Be 25. Wes case reterred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of After 4√ Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: All completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 1 Cartifying Phyelctan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of certifier death (Item 23a) (Type/ Print) 31. Date tiled (Month, Day, Year)

JAN 1 3 1999

Registrar

State



# Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

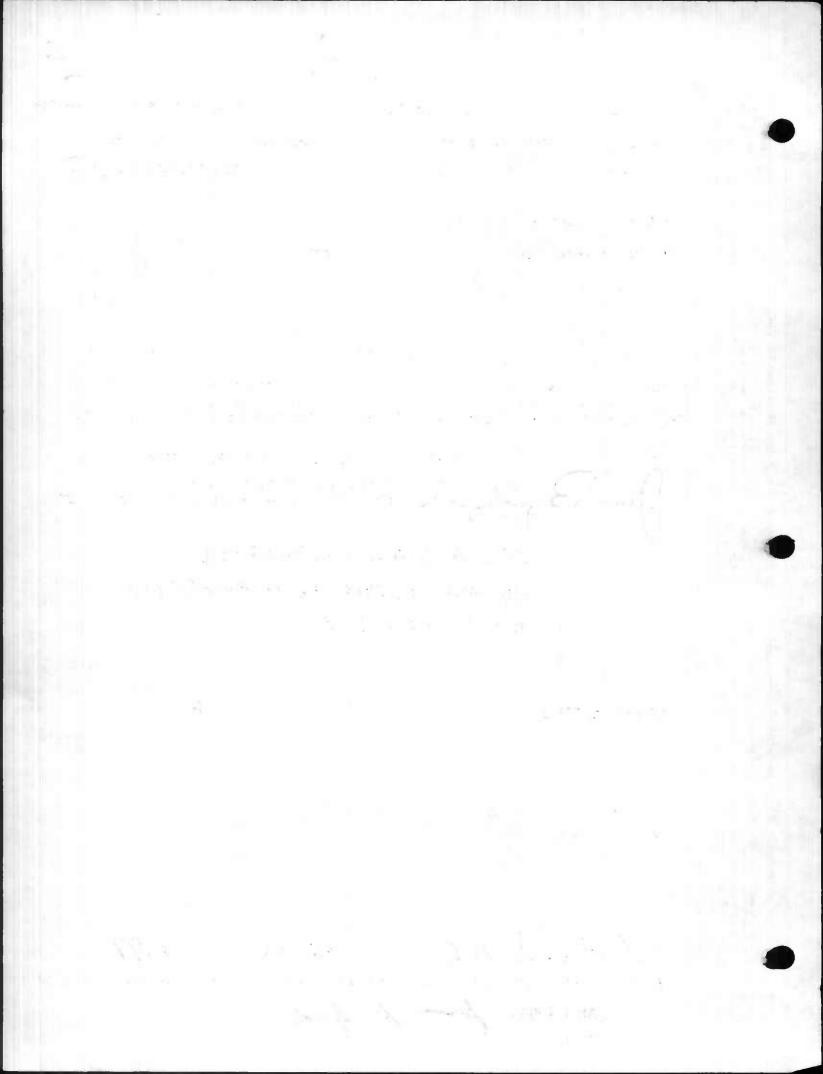
Certificate of Death 2. Date of Deeth 3 Time of Death 1 Decedent's Name (First Middle Last) Month Dey **Physician** January 7, 1999 1:00 AM Delma Westmoreland Μ. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner Rossville Baltimore Franklin Square Hospital Center 8. Date of Birth Mar. 17,1913 If Under 1 Year 5. Sociel Security Number If Under 24 Hrs. 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2√2 F Months Deys Hours Min. Maryland 85 218 18 7798 Yrs. **Director** Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Empirior must be published at page. 10e, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland | Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1631 Turkey Point Road 21221 Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Stetus Bleck, White, etc. 1 ☐ Never Married 2 M Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) Assembler Areo-Space 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Thurmond Morris (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billy S. Westmoreland (Husband) 1631 Turkey Point Road Essex, Maryland 21221 20e. Method of Disposition 20b. Pieca of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 N Buriel 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Holly Hill Mem. Gardens 1/11/99 Baltimore County, Md 21. Sgnature of Funere Service Licenses 22. Name and Address of Eacility
Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one pause on each line. Onset and Death **Physician** e. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DIS

Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner ettending physician and for use es the burial-transit death certificate be executed Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last HYPERTENSION Box 68760. Physician/Medical P.O. I ed by the e Part II. Other eignificant conditions contributing to deeth but not resulting in the undarlying cause given in Part I. 23h. Did tohacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown signed by t EMENTIA Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? been si 24a. Wes an autopsy performed? Completed i certificate has b director, pege 2 s 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 15 Inpetient 2 ER/Outpatient 3 DOA this funeral 28d. Describe how injury occurred 27. Menner of Death 28b. Time of Injury 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) Certification: After 5 Pending investigation after death. Director: Aft 1 Yes 2 No ector: A 2 Accident 6 Could not be determined 3 Sulcide 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) the Funeral Director of Filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. edicai within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated. (Check only 29b. Signature end title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (item 23e) (Type, Print) ADOLPIT WYCHUZI M. 1 8100 Harford Road Baltimore, Md 21214 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State JAN 1 3 1999

Registrar



# Please Type or Print In Black indelible Ink. Assure All Copies Are Legible.

	Item:5per F.H G-767 1	State of Marylar 1/13/99 reb		ate of Death	)	Reg. No.	UU	3-24				
Physiciar * /Medica		Largin			2. Date of D Month Ja V	. 9 19	Year 99	3. Time of Deeth				
Examine Funeral Director	4a Facility Name (If not institution, of Mercy Med	5. Social Security Number 6. Sex 1 M 2 DF 7. Age (In yrs. lest birthday) 1 Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 7. Age (In yrs. lest birthday) 9. Birthplace (Si Country) 9. Birthplace (Si Countr										
how	10a. State 10b. County	10c. C	ity, Town or Location			10d. Inside City Limits						
with the Maryland a or 28a-f ahow Lbe notified at	MD NA	Dateimore						Yes 2□No				
with it	10e. Street and Number 215 Beale Co			Zip Code		10g. Citizen of V		7				
hours after death with the Mar hours; or items 23s or 28s-f at Examines must be notified	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give	J,S. 13. Wes De If Yes, s	21231 seedent of Hispanic Or specify Cuben, Mexical Specify Specify Specify			e - Americen k, White, etc.					
5-002 72 hours natural',	Widowed 4 □ Divorced  15. Decedent's	Year or Dates:	16a. Decedent's L			16b. Kind of Bu	DIa					
2121 I within jiane.	15. Decedent's (Specify only highest) Elementary/Secondary (0-12) 12th Grade 17. Father's Name (First, Middle, La		(Give kind of work done during most of workii			Laborer						
be filed tal Hygied other went,	17. Father's Name (First, Middle, La	st) -			er's Name (First, Midd	le, Maiden Sumem	10)					
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ages 1 sent of He	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spe	Li Hemoval from State	Place of Disposition ( cemetery, cremetory	Neme of or other plece)	Date A Cem.Ol-	20c. Location -	City or Town,	, Stete MD .				
Baltimo	21. Signeture of Funeral Service Lic		22. Name	and Address of Facil		ore, Ma	rylan	d 21202				
6876( ficate be physicia	Immediate Ceuse (Final disease or condition resulting in death)  Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last	b. Metast Due to (	(or as a consequence or as e consequence	on ces	(color	.)						
Box (eath certif	Book II Other elevisions and discon-		author in the underhile	en acusa chian la Bad	1 22h Di	d tobacco use co	ntribute to th	e cause of death?				
P.O. de by the detache	Part II. Other significant conditions	s contributing to death but not re	suiting in the undartyir	ng ceuse given in Par		Yes 2 No	3 Probab	4				
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	5				10	Yes 2 No	1 🗆 Y	'es 20 No				
Of Vita Physician: this certific ral director.	25. Wes cese referred to medical examiner?	Hospital:		Other	ce of Death (Check only	1						
		28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	Residence 6 Other (Specify) cribe how injury occurred								
Division of To the Hospital or Attending Physician 24 hours after death. To the Funeral Director: After the completaly filled in by the funeral Medical Certification.	3 Suicide 6 Could no determina	28e. Place of Injury - At the building, etc. (Special	nome, farm, street, fac ify)	ctory, office	28f. Location City or 7	(Street end Numb own, Stete)	oer or Rural R	oute Number,				
he Hospi in 24 hou he Funer pletaly fill		(Check only 2   Medical Examiner: On the basis of examination and/or investigation. In my opinion, death occurred at the time, date and place, and due to the ceuse(s)										
To the com	29b. Signeture and little of certifier	le Al		29c. License number	4 )	29d. Date signed	. 9,	1999				
	30. Name and address of person w	no completed cause of death (ite	om 23e) (Type, Print)	ne St.	Intern	al Me	dich	ne				
State Registrar	I IAAI 3	1999 32. Registrer's Sign	A.	Spark								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Item#1 per Phy G767 1/19/99 EW Certificate of Death nt's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Darlena Maria Month 15 Physician 1000 /Medical or Location of Death e Facility Name (If not institution, give str City, Toy Examine ME OVER UB 5. Sociel Security Number 7. Age (In yrs. last Birthplace (State or Form; Country) 8. Date of Birth (Month, Dey, Year) 6 Sax **Funeral** 1 M aX F Days Hours Director 219-62-5013 43 DEC. 6. 1955 Florida Usuel Residence of Decedent 72 hours efter death with the Marylend 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show edical Exercise must be notified at Yes 2 No Director N/A Maryland Baltimore 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 501 W. Franklin Street 21201 USA Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U.S. 11. Maritel Status Armed Forces?

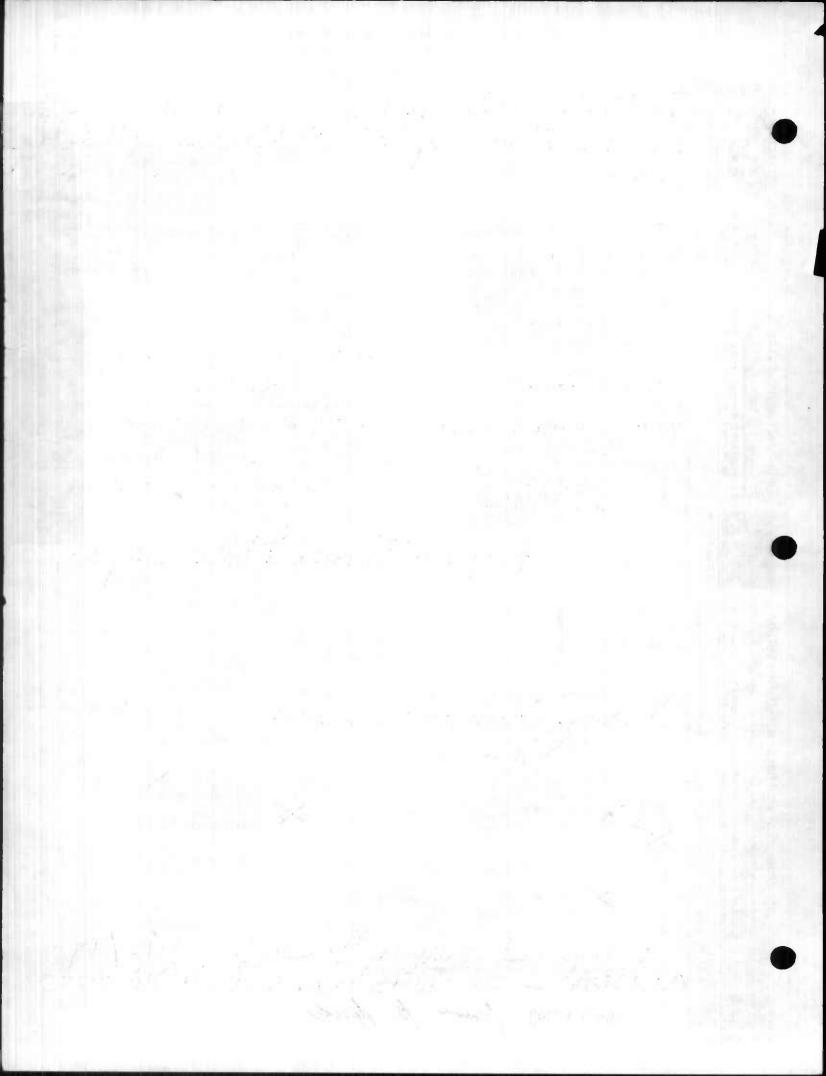
1 Yes 2 No
If Yes, Give
Yeer or Detes: Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify by 3 ☐ Widowed 4 ☐ Divorced Black nd 2 should be filed within 72 hour sith and Mental Hygiene. 27 is marked other than "natural or traumatic event, tra Medical E. Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18 Mother's Name (First Middle Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Ezell Alexander Laura Hickey 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) permit. Pages 1 end 2 sh Depertment of Heelth end Important: If Item 27 is m any injury or other traum once. 2421 Harlem Avenue Baltimore, MD 21216 Charles Henry Johnson, III/son 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Metro Crematory, Inc. 1/13/99 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility
Cremation Society of Maryland, Inc. 21. Signeture of Funeral Service Licenses Dawn F. 10 McDonald K 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deetl **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be executed physician end the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical thet initieted events Due to (or es e consequence of): resulting In death) Lest attending p for use as 98 signed by the a 23b. Did tobacco use contribute to the cause of death? Pet II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Probably 4 Unknown 1 ☐ Yss 2 ☐ No þ 24b. Were autopsy findings available prior to been signal Completed 24e. Wes en eutopsy performed? completion of ceuse of death? certificate has b lirector, page 2 s Nio 1 Yes 1 ☐ Yes 2 ☐ No Physician: director, 25. Wes cese referred to medical exeminer? Be 26. Piece of Death (Check only one) Other: 1 Yes 2 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this : After this funeral 27\_Menner of Deeth 28c. Injury at Work? 28e. Date of fnjury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of or Attending 1 Devleturel 5 Pending in 24 hours after describe the Funeral Director: After Triang in by the fur 1 Yes 2 No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifie who completed ceuse of deeth (flurn 30. Neme end eddress of person MPIN

State Registrar 31. Dete filed (Month, Day, Year)

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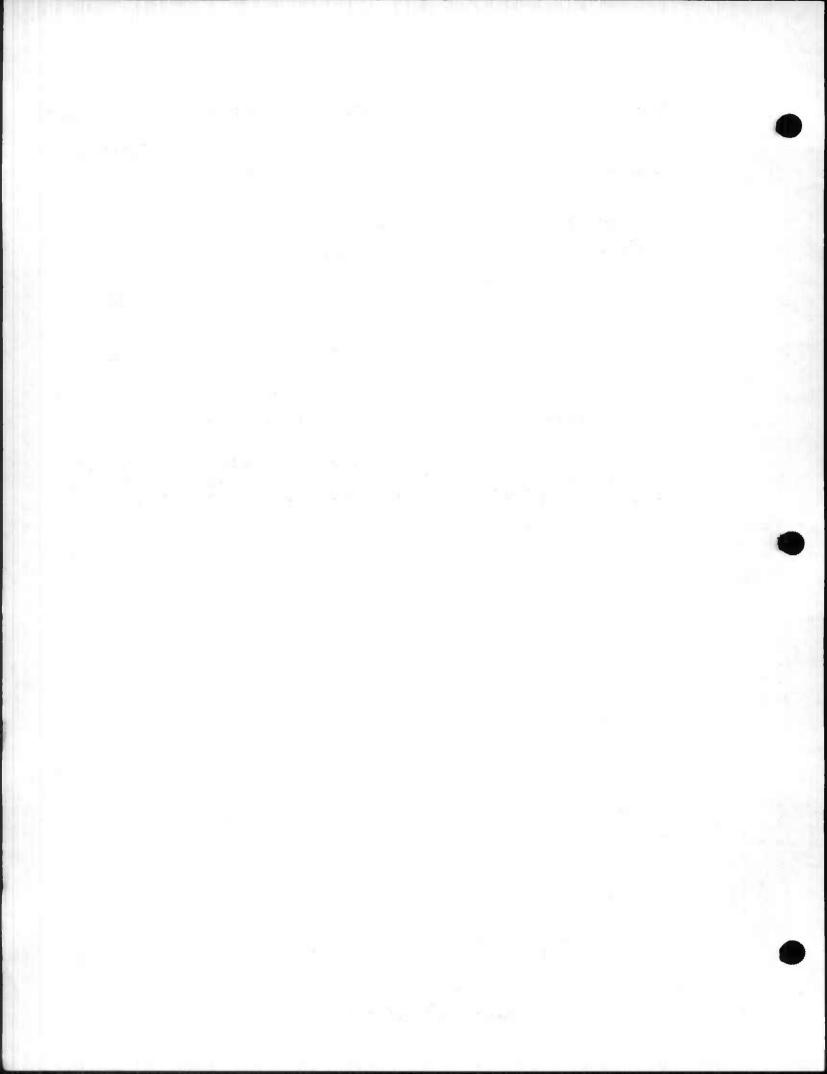
32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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			*	ber)			4b. City, Town, or		4c. County		J. IJMII	
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		218-18-3156 ★ M 2□ F			yrs. lest birthday)  95 Yrs.  If Under 1 Yeer   If Under 24 Hrs.   8. [ Months Deys Hours Min.   0. [ Degree Hours Min.			(Month, Day	of Birth h, Dey, Year)  20,1903  9. Birthpiece (State or Foreign Country)  MD			
	-			10c. (	City, Town or Lo	ocation				1	0d. Inside City Li	
tor	1	MD Baltimore			Baltimo	re		1 🗆 Y6				
irec	10	e. Street end Number	_			10f. Zip Code		1	0g. Citizen of V	Vhet Coun	try?	
4e. Fecility Name (if not institution, give streat and number)   130 Slade Avenue #315   35. Social Security Number   6. Sex   7. Age (in yrs. last birthday)   45. City. Town 1218-18-3156   35. Min 2   F   7. Age (in yrs. last birthday)   45. City. Town 218-18-3156   35. Min 2   F   7. Age (in yrs. last birthday)   45. City. Town 218-18-3156   35. Min 2   F   7. Age (in yrs. last birthday)   45. City. Town 218-18-3156   35. Min 2   F   7. Age (in yrs. last birthday)   47. Age	8		U.S.A.									
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	20	a. Method of Disposition  **Disposition   Cremation   Comparison   Com	Removel from St	ate	Place of Dispo cemetery, crer	sition (Neme of metory or other ple	ice)		20c. Location -	City or To	wn, State	
	21	1.	**				-			CIMOI	re,MD	
00		1//	19		8	22. Name and Address of Fecility Sol Levinson & BROS., I 8900 Reisterstown Road-Pikesville, MD 212						
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edical	resulting In death) Lest  Due to (or es e consequence of):											
sici	Pe	rt II. Other significant condition	s contributing to deal	ributing to death but not resulting In the underlying ceuse given in Part I.					23b. Did tobacco use contribute to the cause of death?			
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npieted	24e. Wes an autopsy performed?							24b. We eve cor of o	ere autopsy tindin sileble prior to mpletion of ceuse deeth?			
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Be	25	examiner?	Hospitel:		7550	Otl	hae	eth (Check only on		-11000		
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edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end menner as steted.  2 Medical Examiner: On the bests of examination and/or Investigation, In my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.									eted. the ceuse(s)		
Medical Cert	29	b. Signeture end title of certifier	and.	) mi		29c. Licens	- /		9d. Dete signed			
	30	. Name end eddress of person w	ho completed cause		om 23e) (Type,	Print)	Pikesuil	`		111	/ /	

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nema (First, Middle, Last) 2. Data of Death 3. Time of Death Dev Month **Physician** Marion Ruth Burke January 12, 1999 12:48 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1726 Ingram Road N/A Baltimore Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year)
June 2, 1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours 1□M 2X F Months 73 Yrs. England Director 219-40-8142 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itsms 23s or 28s-f show traumedo event, the Medical Examiner must be notified at Y Yes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1726 Ingram Road 21239 England Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien Bleck, White, etc. 11 Marital Status 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 Yes 2X No If Yes, Give Year or Detes: 1 Never Merried 2 Merried Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ KNo Specify: à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiens. Important: if them 27 is marked other than "natio once. 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Bookeeper Shoe Supplier 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 86 Alfred Wallis Ruth Rea 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Still Pond Drive Ann-Marie Balbier / Daughter New Freedom, PA 17349 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete X Burial 2 ☐ Cremation 3 ☐ Removel from Stete MSVC- Garrison Forest 1/19/99 Owings Mills, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fune el Service Licensee /Timothy Harman 22. Neme end Address of Facility Leonard J. Ruck, Inc. Funeral Home 23a. Part 1. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellule. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Glioblas toma /Medical Immediete Cause (Final diseese or condition resulting in deeth) multi Some Examiner Due to (or as e consequence of): Examine attending physician end for use as the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of): signed by the at id be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death?

3 Probably 4 Unknown 1 Yas 2 No

welliter, hypercholestustenia

24b. Wera autopsy findings available prior to 24e. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

25. Was case referred to medical axaminer? 1 ☐ Yes 2 No 27. Menger of Death 1 Neturel 5 Pending investigation

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

4 Homicide

3 Suicide

p

Completed

Be

10

Certification:

Medical

State Registrar

funeral

After

ne Hospital or Attending P in 24 hours after death. The Funeral Director: After to

To the Hosp within 24 hor To the Fune completely fi

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

Bultimore

26. Place of Deeth (Check only one)

29b. Signatura and titla of certifier

6 Could not be

246197

29c. License number

29d. Data signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

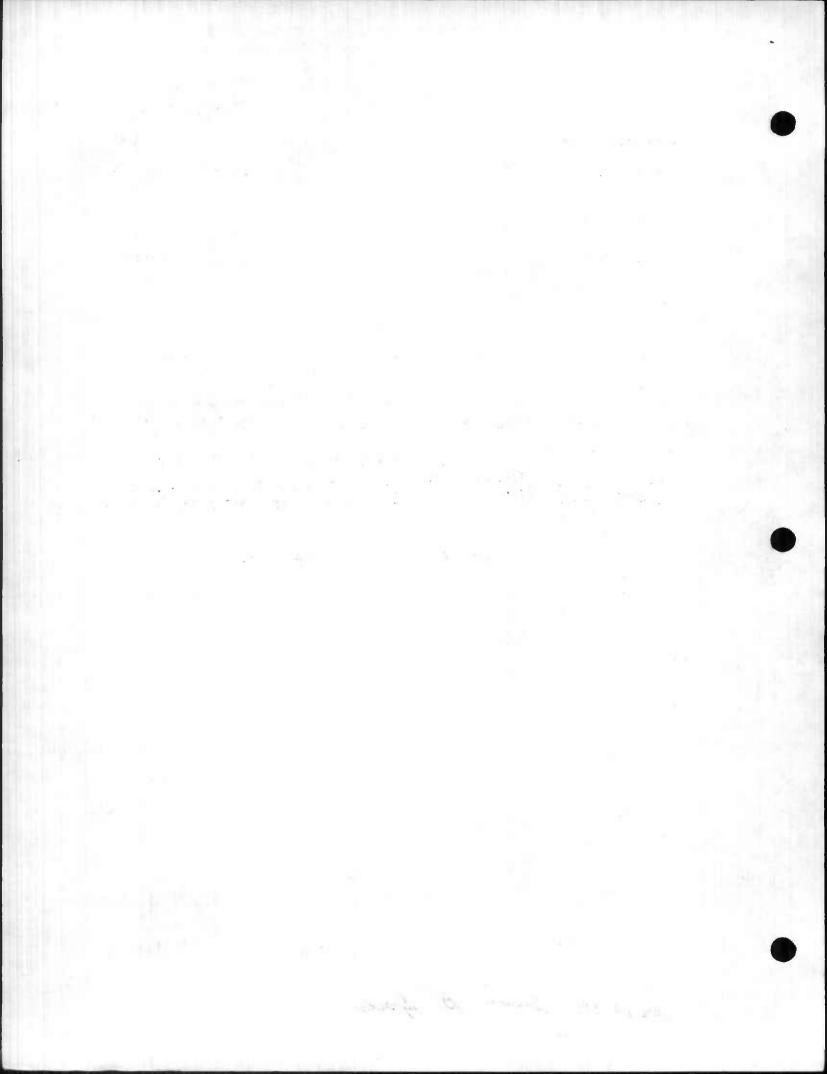
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my

Mirandi 31. Dete filed (Month, Dex Your)

Park Drive 3100 W 1 man 32 Registrer's Signature

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Day Month **Physician** HUBERT Savor Ry 10 1990 Sation of Death 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) Examiner Howard County General Hospital Columbia Howard If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Deys 10 M 20 F Yrs. 171-01-8820 APR 5, 1920 Pennsylvania Director Usuai Residenca of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Itema 23a or 28a-f ahow 1 ☐ Yes 2 ☐ No MD Howard Elkridae 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number S 21075 pemit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a and injury or other traumatic event, the Medical Exercises man and page. 8029 Paul Martin Drive USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Merried 2 Merried 1 Yes 2 XNo Specify: white P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Auto 12 Mechanic 18. Mother's Nama (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Leonard Bast Christina Schmidt 19a. Informant's Nama/Ralationship (Type, Print) 19b. Malting Addrass (Straet end Number or Rurel Route Number, City or Town, Stete, Zip Code) Emilie Bast - wife 8029 Paul Martin Drive, Elkridge, Md. 20b. Place of Disposition (Nema of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a, Method of Disposition Date 01/13/99 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Pk. Elkridge, Md. 4 ☐ Donation 5 ☐ Othar (Spacify) 22. Name end Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 23a. Part1. Enter 1 disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician Immediate Cause (Finat disease or condition resulting in death) /Medical · Carpiogenia Examiner Dua to (or as a consequence of): Physician/Medical Examiner o carpia The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disaase or injury that initiated evants resulting in death) Last attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part ii. Other elanificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributa to the cause of death? tha signed by t 1 Yee 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings evalleble prior to completion of cause of death? 24a. Was an autopsy performed? Completed need s certificate has b page 1 ☐ Yes 20 No or Attanding Physician: Be 25. Was case referred to medical 26. Piaca of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 0 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury af Work? 28d. Describe how injury occurred Certification: After 1 Dalaturat 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: / 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) aftar 4 Homicida To the Hospital of within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29e. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartified 29c. License number Tromers 11/1200 30. Neme and eddrass of person who compiated cause of death (Itam 23a) (Type, Print) Little Pahixend ( William 11055 Flower m11 31. Dete fited (Month, Dey, Year) 32. Registrar's Signature State

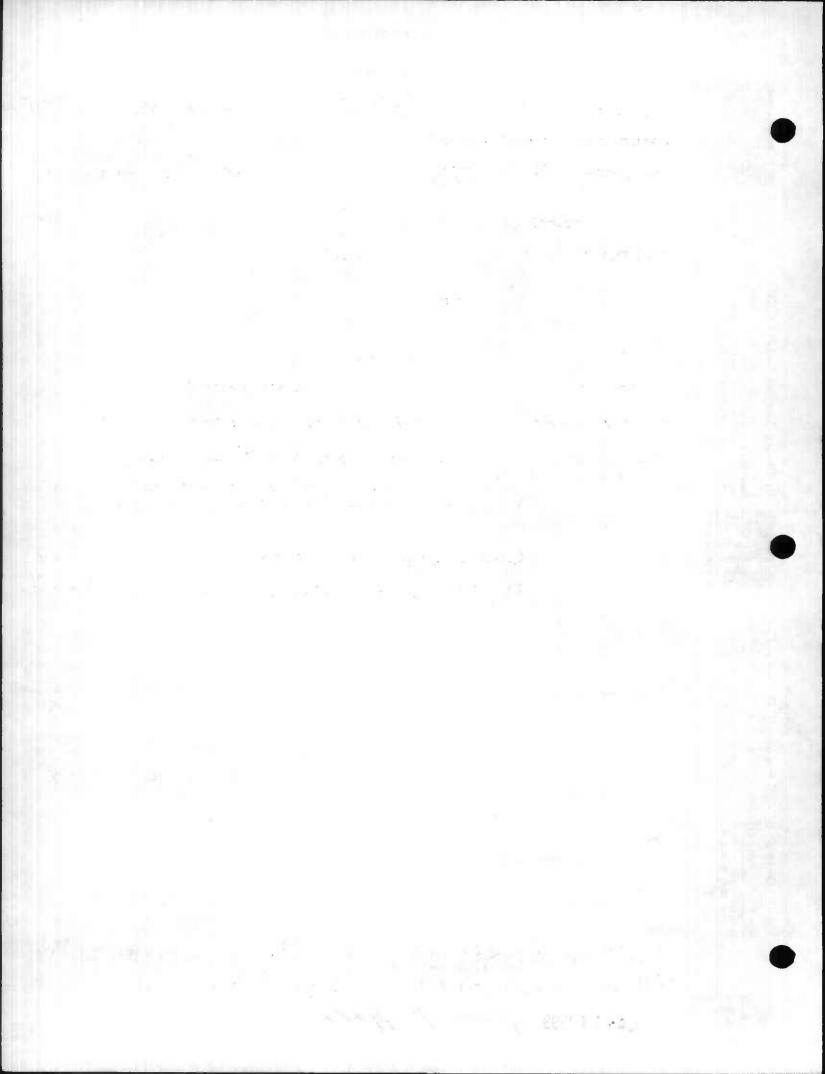
BHMH 16.5

**DHMH 16 Rev 6/95** 

Registrar

IAN 1 4 1999

32. Registrar's Signature Selves B. Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 00539 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Mary Margaret Black January 4, 1999 8:50 p.m. 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Death Cumberland
| if Under 24 Hrs. | 8
| Hours | Min. Memorial Hospital & Medical Center Allegany If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1□ M 2□ F Months 214-07-1837 81 26, 1917 Feb. Maryland Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. fnside City Limits Allegany Maryland Cumberland 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 229 Baltimore Avenue 21407 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rose K. Kirby George W. Smith 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 851 Mt. Royal Avenue, Cumberland, Maryland 21502 Carl Black/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 5 Other (Specify) 4 Donation Wade, Kona Lo State Anatomy Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201 ter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final ACUTE CEREBROVASCULAR ACCIDENT 10 DAYS disease or condition resulting in death) Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION 1 WEEK Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury fhat initieted events resulting in death) Lest Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I 1 Yee 2 No 3 Probably 4 N Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 NO 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 SInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation Injury 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

158 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29c. License number

D 23371

29d. Date signed (Month, Day, Year)

January

1999

The law requires that the death certificate be executed Box 68760.

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

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**Funeral** 

Director

pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified an Page.

Physician /Medical

Examiner

attending physician and for use as the bunal-transit

Examiner

Physician/Medical

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Certification:

Medical

4 Homicide

(Check only one)

29b. Signature of little of certifier

29a. Certifier

Baltimore, Maryland 21215-0020

ed by the Division of Vital Records, P.O. signed by t should I is certificate has b I director, page 2 s Hospital or Attending Physician: this Aftar death. # 0

funeral rector: / Direct In by within 24 hours aft To the Funeral Di completely filled In

State Registrar

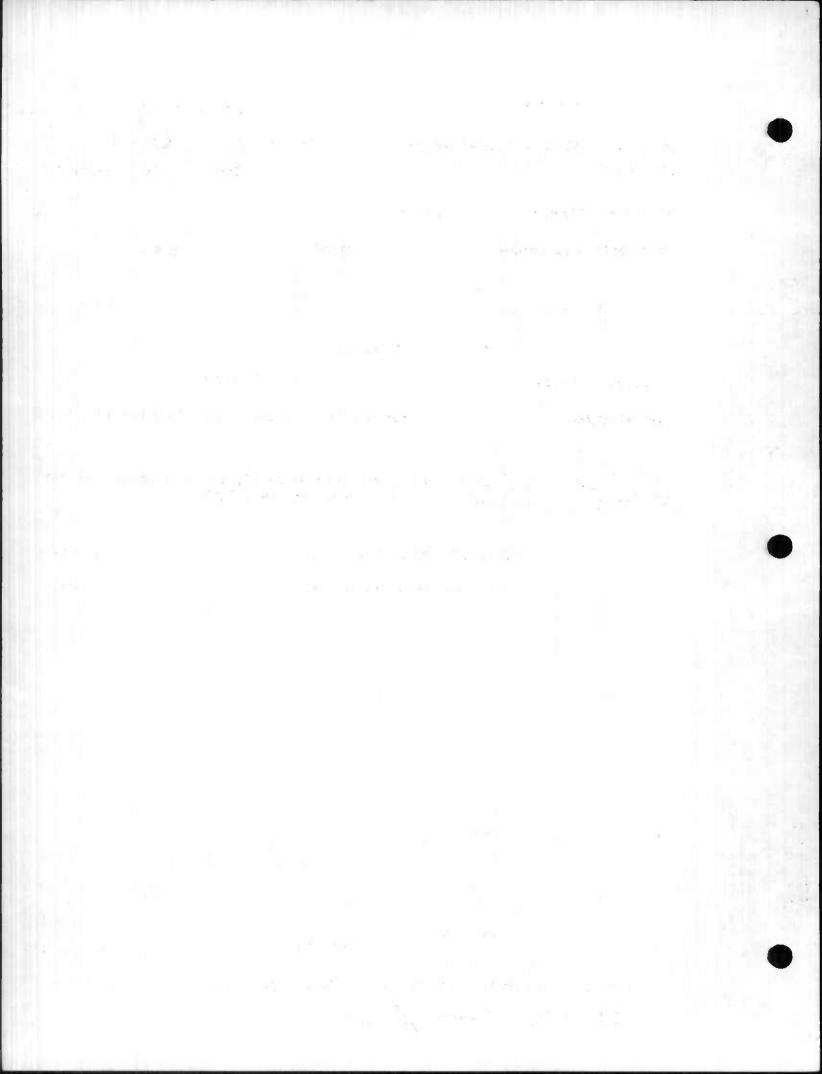
31. Date filed (Month, Day, Year) " 1999

mon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



**DHMH 16 Rev 6/95** 



P.O. Box 68760. Division of Vital Records. **Physician** 

/Medical

Examiner

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Hygiene. other than "natural", or items 23a or 7 vent, the Medical Examiner must be a

7 is marked other treumstic event,

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**Physician** 

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Examiner

Physician/Medical

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Certification:

Medical

(Check only one)

29b. Signeture end title of costifie

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Funeral

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filed within 72 hours efter deeth with the Maryland

altimore, Maryland 21215-0020

that the death certificate be executed or Attending n 24 hours after des ne Funeral Director nietely filled in by th To the Hosp within 24 ho To the Fune completely fi

State Registrar

31. Dete filed (Month, Day, Year) 11/JAN 14 1999

TARIQ

MAHMUUD 32. Registral Signetura

30. Nema and eddrass of person who completed cause of deeth (Item 23e) (Type, Print)

Euraw St #308 Baltimore MD 21201 821 N

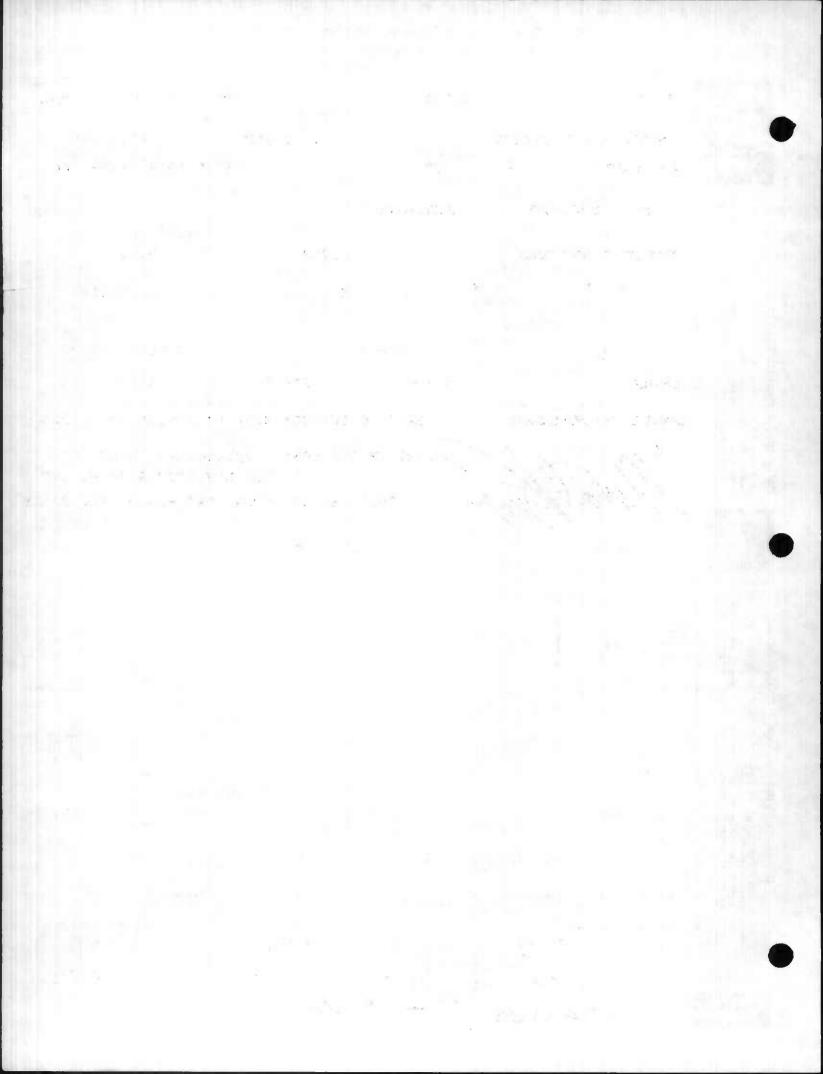
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the ceuse(s) end menner steled.

29c. License number

D43725

29d. Date signed (Month, Day, Year)

**DHMH 16 Rev 6/95** 



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Elsie Marie Coppard 4:59 P.M. 12 1999 JANUARY 4c. County of Deeth 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death BAITIMORE FRANKlin SquARE Hospilal Ale Center 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 M 25 F Yrs. 219-20-1748
Usuel Residence of Decedent 84 March 3,1914 Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Rosedale 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6600 Ridge Road 21237 United States 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Unknown Own Home 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) James Timmons Maude Gladman 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn Harby/Attorney 309 S. Conkling Street Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town. Stele XI Burlel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith Cemetery 1/14/99 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter the disease, or complications and caused the shock, or heert feilure. List only one ceuse an each line. Approximate Interval Between Onset and Deeth not enter the mode of dying, such as cardiac or respiretory errest, Immediate Cause (Finel CARDIOMYOPAI diseese or condition resulting in deeth) VEAR Due to (or as a conse ongeslive HEAR Due to (or as a consequence of): Due to (or es a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** 

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page 2

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or Attending Physicien: after death. Director: After this certific

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pemii. Pages 1 end 2 should be file Department of Heelth and Mental Hy Important: If Item 27 Is marked oths eny Injury or other traumests

**Physician** 

/Medical

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7 is marked other than "natural", or flerns 23a or 28a-f show traumatic event, the Medical Examinat must be notified at

Or 1

Maryland 21215-0020

Baltimore,

Box 68760.

P.0.

Records.

Division of Vital

OPPARO

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Physician/Medical by

> Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No

Netural 2 Accident investigation 6 Could not be determined 3 Suicide

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28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29b. Signeture and title of confile 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

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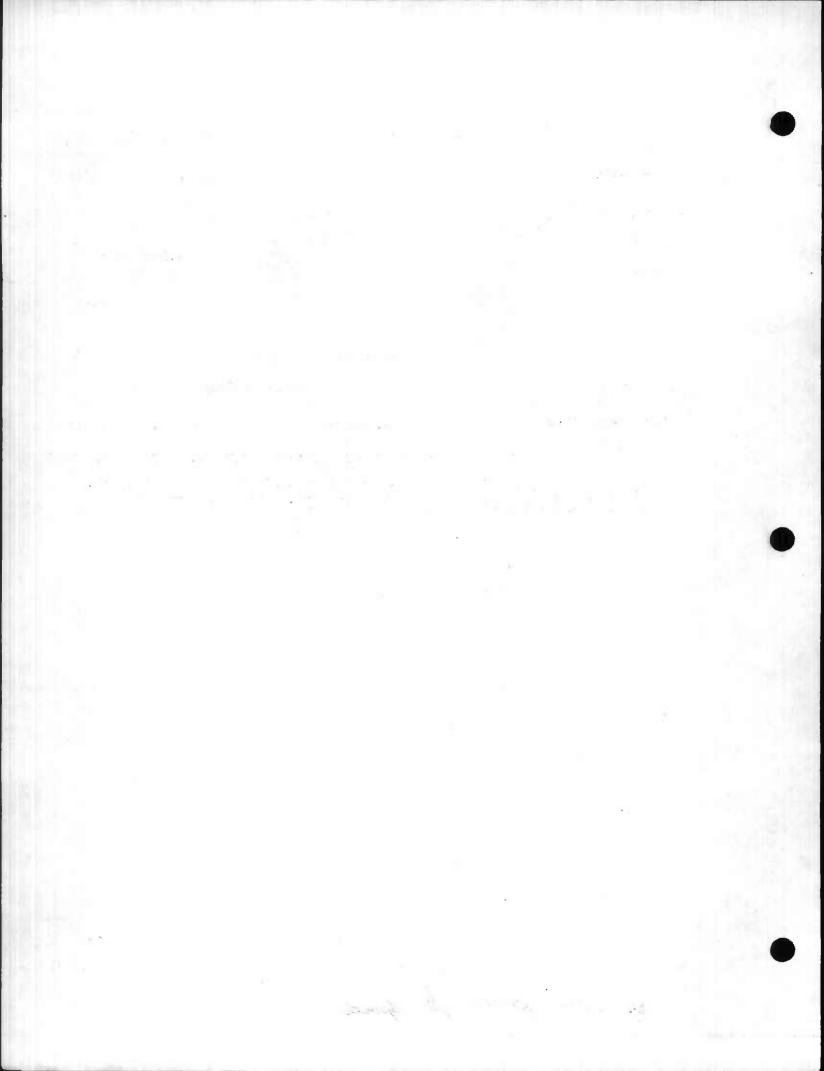
32. Registrar's Signato

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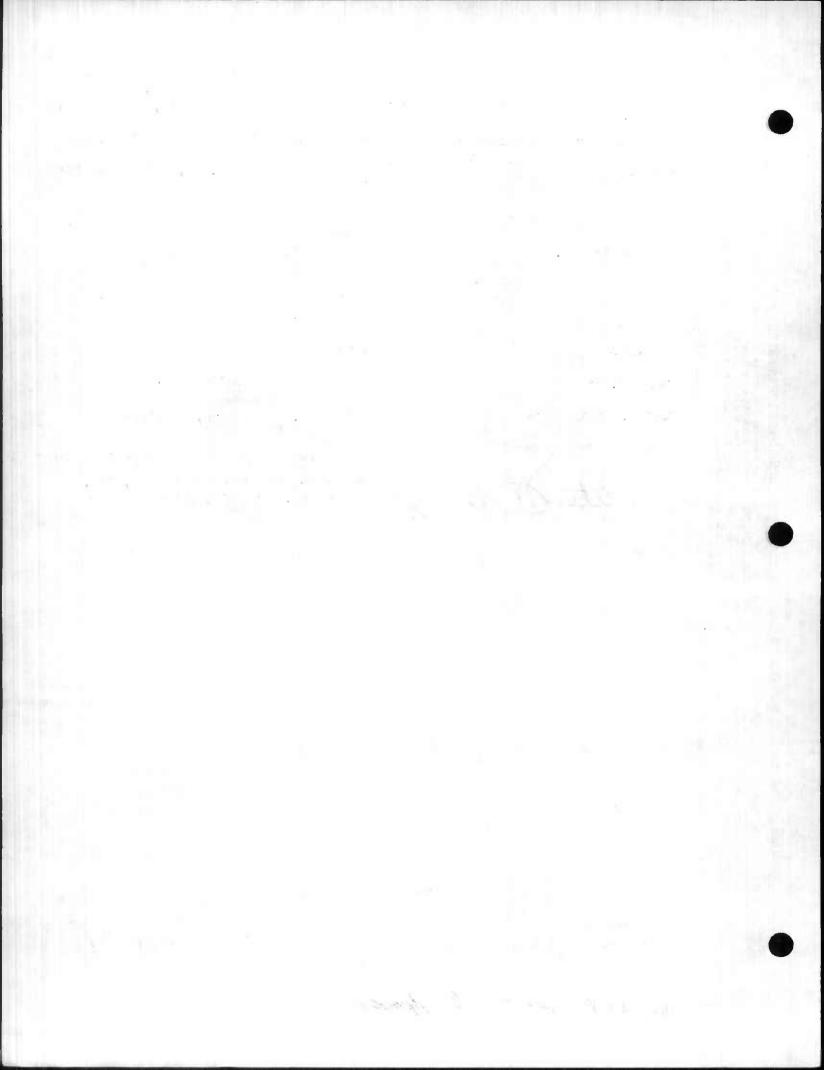
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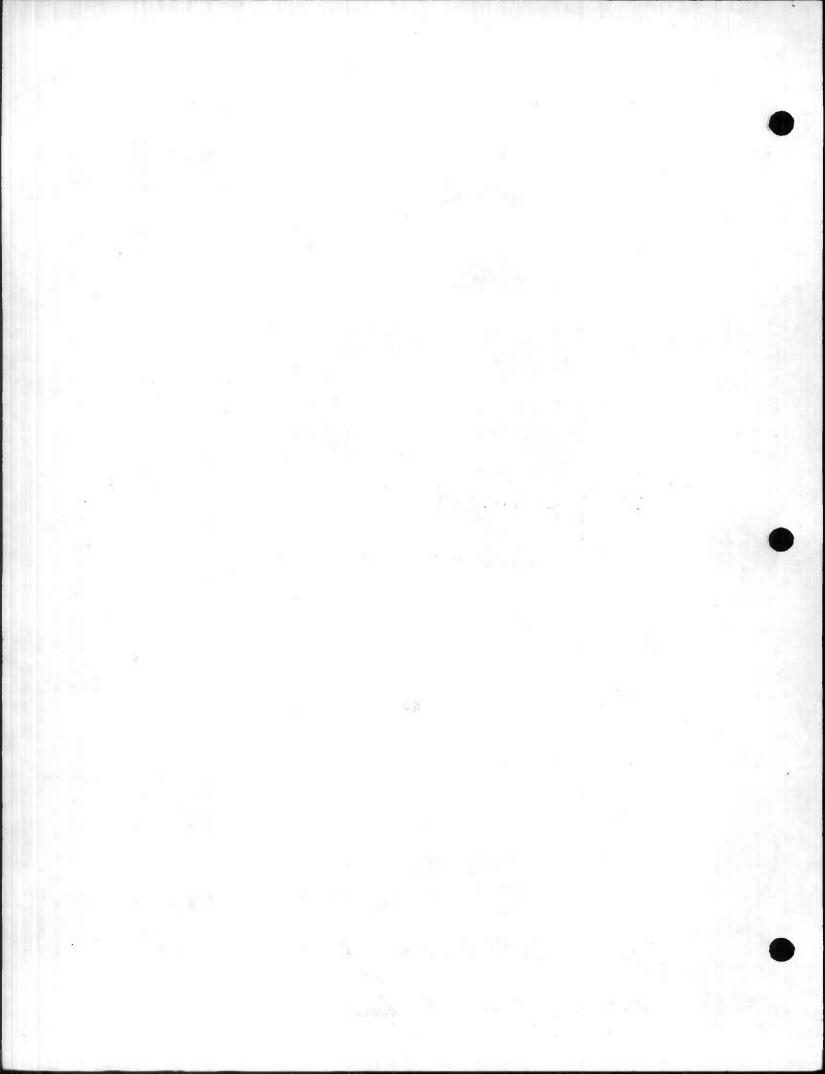
State of Maryland / Department of Health and Mental Hygiene 9 0 5 4 2

				C	ertificat	e of	Death			Reg. No.				
	1. Decedent'e Name (First, M								2. Date of D Month	eath Day	Year	3. Time of Death		
Physician /Medica	MAD OF THE	Dais	sy Eller	Col:	lis				_			12:20 PM		
Examine	4e Facility Neme (If not instit	ution, give street end nu	ımber)				4b. City, To	own, or Lo	cation of Dea	2				
	Franklin Sc	uare Hospit	tal				Ros	eda1	e	E	3altim	ore		
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs.		y) If Unde	1 Yeer Days			9 Date of B	irth	9. Birthi	place (State or Foreign		
Director	218-36-2541 Usual Residence of Deceden	1□ M 3€xF	77	Yrs.	I WOTE TO	Dayo	110013							
death with the Maryland ms 23a or 28a-f show Linual be notified at	10a. State 10b. Co	unty	10c. City	y, Town or	Location							10d. fnside City Limits		
the Maryle 28a-f shorn notified at	Maryland Baltimore Edgemere  10e. Street end Number  2903 Wells Ave.  11. Marital Status  1 Never Married 2 Merried  10f. Zip Code  10f. Zip Code  10f. Zip Code  10f. Zip Code  110f. Zip Code											1 ☐ Yes 2☐ No		
or 28	10e. Street end Number 10f. Zip Code									10g. Citizen	of Whet Cou	ntry?		
th with	2903 Wells A	ve.					212	19		United	State	es		
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020 urs s	3 ☐ Widowed 4 ☐ Divo	Merried 1 ☐ Yes If Yes, Gi	1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:		1 Yes 2 No Specify:				, r nozn, oto.,		Specify:			
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and and man	Earl L. Coll	is / Husban			03 We		Ave.	Edg		-				
Baltimore, Maryland 212: permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than may injury or other treumatic event, in a monta.	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremet	ion 3 PRemovel from		emetery, c	position (Ne remetory or	me or other ple	ce)	i	Dete	20c. Locatio	n - City or T	own, State		
Fament:	4 Donation 5 Othe			est I	awn Co	emet	ery	1/14/	/1999	Syk	esvil	le, Maryland		
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/Medical	Immediate Cause (Finel disease or condition		Dnei	un	m	d					- 4	10 dous		
Examiner	resulting in deeth)			ra car	equence of)									
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certificate be exerting physician a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or es a consequence of):  Cause (Disease or injury that initiated events  Due to (or es e consequence of):													
6876(ficata be physicia to the builded	that initiated events resulting in death) Last	Cause (Disease or Injury that initiated events resulting In death) Last  Due to (or es e consequence of):												
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_ D D D	Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of e					
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The law requires the law requires to has been sign page 2 should be completed by									24e. We	s en autopsy formed?	24D. W	Vere eutopsy findings veilable prior to completion of cause		
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f Vital Repairs of Vital Relations of Vital Relatio	25. Was case referred to me examiner?	dical	/				26. Plac	a of Death	(Check only	one)				
- 2 00	1 ☐ Yes 2 ☐ No			ER/Outpat	ient 3 D	Otl AC	ner: 4□ N	ursing Ho	me 5 Res	sidence 8 🗆	Other (Speci	ify)		
ng Phy her thi meral	27. Manper of Death	28e. Date (Mon	of Injury oth, Day Year)	28b. Time fnjury	of	28c. Inju	rk?		28d. Describe	how injury oc	curred			
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Division can or Attending Person after death.  In Director: After to be									28f. Location (Street end Number or Rural Route Number, City or Town, Stete)					
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Division O To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the tuneral	29a. Certifier 1 Cert (Check only one) 1 Medi	ifying Phyefolan: To the caf Examiner: On the b and man	e best of my know easis of examinal ener stated.	wledge, de tion and/or	eth occurred investigetion	at the ti	me, date er opinion, dec	nd place, a eth occurr	and due to the ed at the time	e cause(s) end , date end pta	manner as a ce, end due f	stated. to the cause(s)		
To the To the Comp	29b. Signature and title of cer	tifier					se number			29d. Date sig	ned (Month	, Day, Year)		
	Ilonelo	autar	osic	M	2	0-	280	97		1-1	2-9	9		
	30. Name and address of per	son who completed care	se of death (item	23a) (Tvn								-		
n	1012	SLD NOR	TH PT	Rd	B	et.	Md	, 21:	224					
State	31. Dete filed (Month, Dey, Y	ear) 32_F	Registrer's Signa	ture /			1 6		<u>.</u>		_	V 100		
Registrar	JAN 1 4 1999	1	10.	popo	uls!									



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	Physicia /Medica	n	1. Decedent's Name (First, Middle CHRISTINE							2. Date of Deat Month JANUAR		Year 999	3. Time of Death 7:30 Am	
	Examine	er	4a Facility Name (If not institution  1 0 0 0 ELLI(  5. Social Security Number	COTT DRIVE	EWAY		) If Under 1 \	BA	Town, or Lo	8. Date of Birth		V/A	blace (State or Foreign	
	Funeral Director	5. Social Security Number  2 1 8 − 2 6 − 4 4 0 6  Usual Residence of Decedent  6. Sex  1 □ M 2 1 F  7. Age (In yrs. last birthday)  6 9 Yrs. Hours Min.												
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21215-0020	within 72 ene. than *nat	Completed		t's Education st grade completed) College (1-4c					ost of work	16b. Kind of Business/Industry  Dr. Marvin Famil				
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/iar		0	Charles W.	Sparrow				A	Alice Victoria Po					
, Maryiand	CENL		19a. Informent's Name/Relations Lakisha M.	ship (Type, Print) HOOd				icott	Dri	al Route Number, City or Town, State, Zip Code) veway, Balto., md 21216				
Baltimore,			20e. Method of Disposition  1 \bigsee Buriel 2 Cremation 4 Donation 5 Other (S	Cem.	Owings Mills, MD									
68760,	aw requires that the death certifica has been signed by the attending ph 2 should be detached for use as the pletted by Physician/Med	edicai	23a. Party Enter the desease of shock, or heart failure List Immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	a. Caro  b  c	Due to (		quence of):	413					Interval Between Onset and Death	
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Vital	stan: octor,		25. Was case referred to medica axaminer?	1					ace of Deel	h (Check only on	ne)			
ō	fing Physician:  After this certific funeral director,	01 :10	1 ☐ Yes 2 No  27. Manner of Death  Nother S ☐ Pendir	79		ury 28b. Time of 28c. Injury at 28d. Describe Work?						esidenca 6 Other (Specify) pe how injury occurred		
Division	after death.  Director: After d in by the fune	Certification:	2 Accident invests 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	8e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
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)	To T To t	2	29b. Signerore and title of certifie	1 Selle	Mille	u w	5 29c. Li	232	238	5 2	9d. Date signed	3/	Day, Year)	
	30.0		30. Name and eddress of person	who completed cause of	death (Iter	m 23a) (Type,	Print)							

Registrar

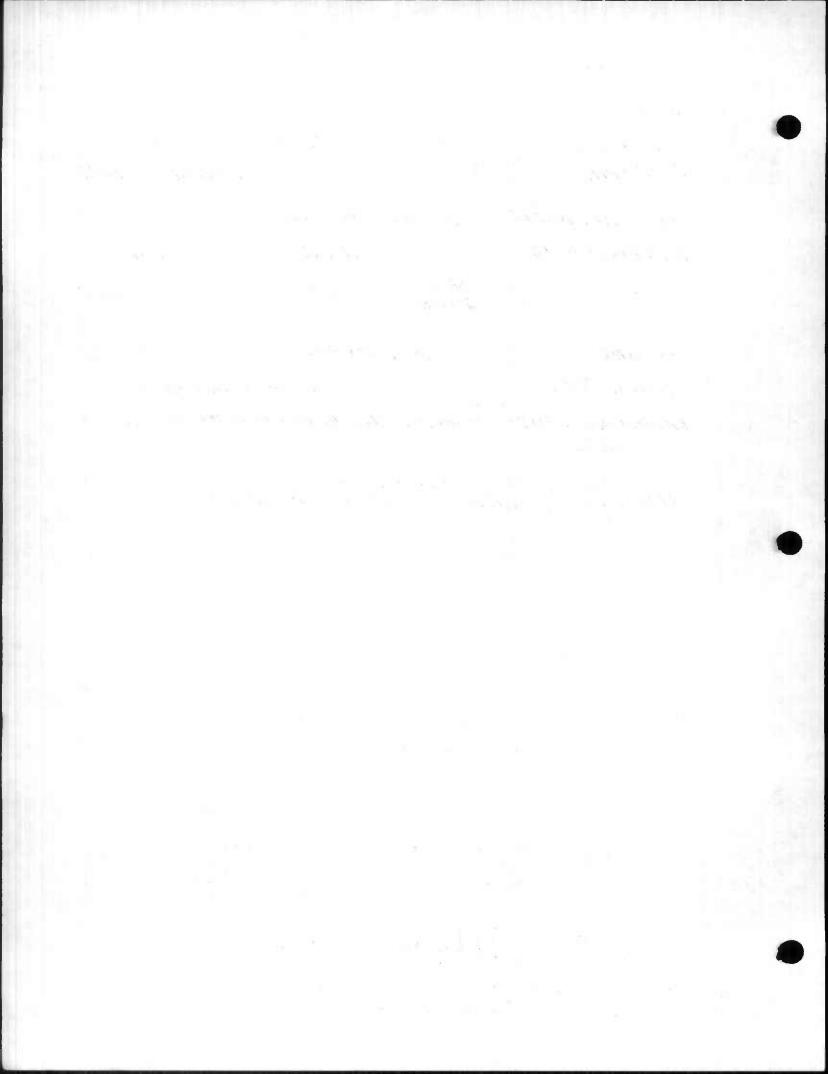


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 00544

Item 20a Per A.B. Film G767 1-14-99 rja Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 99 6:45 A Word Davis 08 /Medicai 01 4e. Fecility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Johns Hepkins Bayview Hospital

5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Bultimore Baltimore If Undar 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, 10 - 22 Birthplece (Steta or Foreign Country)
 FENN **Funeral** 1 € M 2 □ F 208-10-447 Months Deys Hours Min 87 Director Usuel Rasidence of Decedent 10b. County 10a. State 10c. City. Town or Location Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Insida City Limits BALTIMORE HI) 131 TRAILWAY 1 ☐ Yes 2 ☐No Director 10f. Zip Code 10e Street and Number 10g. Citizen of Whet Country? 131 TRAILWAY R) 21220 US4 Funeral 12. Was Decedant Evar In U.S. Armed Forces? 1 ☐ Yes 2 ☐ No WAV Y If Yes, Give Yaer or Detes: 2-19-4#/ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puarto Ricen, atc.) 14. Race - Amaricen Indien, 11. Maritai Status Bleck, White, etc. 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. In end Mental Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) TRON WORKER Construction 5TH GRATE 17. Fethar's Neme (First, Middle, Last) permit. Pages 1 and 2 should be filk Deperment of Health end Mental Hy important: If Item 27 is marked other any injury or other traumatic event 18. Mother's Neme (First, Middle, Maiden Surname) Be LEMON DAVIN NEOMA LEONARI) DAVIS 19a. Informent's Neme/Raletionship (Type, Print) LEGAL 19b. Mailing Addrass (Street and Number or Rural Royte Number, City or Town, Stata, Zip Code) KATHERINE SETTEY GUARDIAN 131 TRAILWAY RI) BACTIMORE M) Q1225 20b. Placa of Disposition (Nema of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Ronald S. 22. Name end Address of Facility State Anatomy Board, 655 W. Baltimore Street Wade Director alle Baltimore, Maryland 21201 Pert1. Enter the disease, or compitations that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immadiata Ceuse (Finel · Preumonia - Aspiration disease or condition rasulting in deeth) 16days Examiner Due to (or es e consequance of): Examiner sician end burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceusa (Diseasa or Injury that initiated events resulting in deeth) Lest Dua to (or es e consequence of): be exec P.O. Box 68760, physician s the burial Physician/Medical Due to (or es e consequence of): 88 esn ettending Pert II. Other algnificant conditions contributing to death but not rasulting in the underlying ceusa givan in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Left femoral neck fracture with subsequent Left Records, 24b. Wara autopsy findings available prior to completion of ceuse of death? 24e. Wes en eutopsy performed? Bipolar Hip Prosthetic Placement 1 Yes 2 No 1 ☐ Yas 2 2 No After this certificate Division of Vital Be 25. Wes casa rafarrad to medical 26. Piece of Deeth (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1-Yes 2 No in by the funeral 28c. Injury et Work? To the Hospital or Attanding Pr within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral 27. Mannar of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Dascribe how Injury occurred Certification: 1-Natural 5 Pending investigation 2 1 No 2 Accident 12/21/98 6 P Fall at Home 6 Could not be datarmined 3 ☐ Suicide 281. Location (Street and Number or Aurel Route Number, City or Town, State) 3225 Old North Point Road Oundalk, MD 21222 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Spacify) 4 ☐ Homicide Itome 1 Certifying Physicien: To the best of my knowledge, daeth occurred et the time, date end place, end dua to the ceusa(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, data and place, and due to the cause(s) end mennar steted. 29a. Certifier Medical (Check only one) 29b. Signature end titla of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 1/8/99 Low 30. Nema end address of person who completed cause of death (Itam 23e) (Type, Print) Kyle Low 3900 North Charles St. APT 508 Baltimore, MD 21218 31. Dete filed (Month, Day, Year)
JAN 14 1999 32 Registrer's Signeture State

Registrar



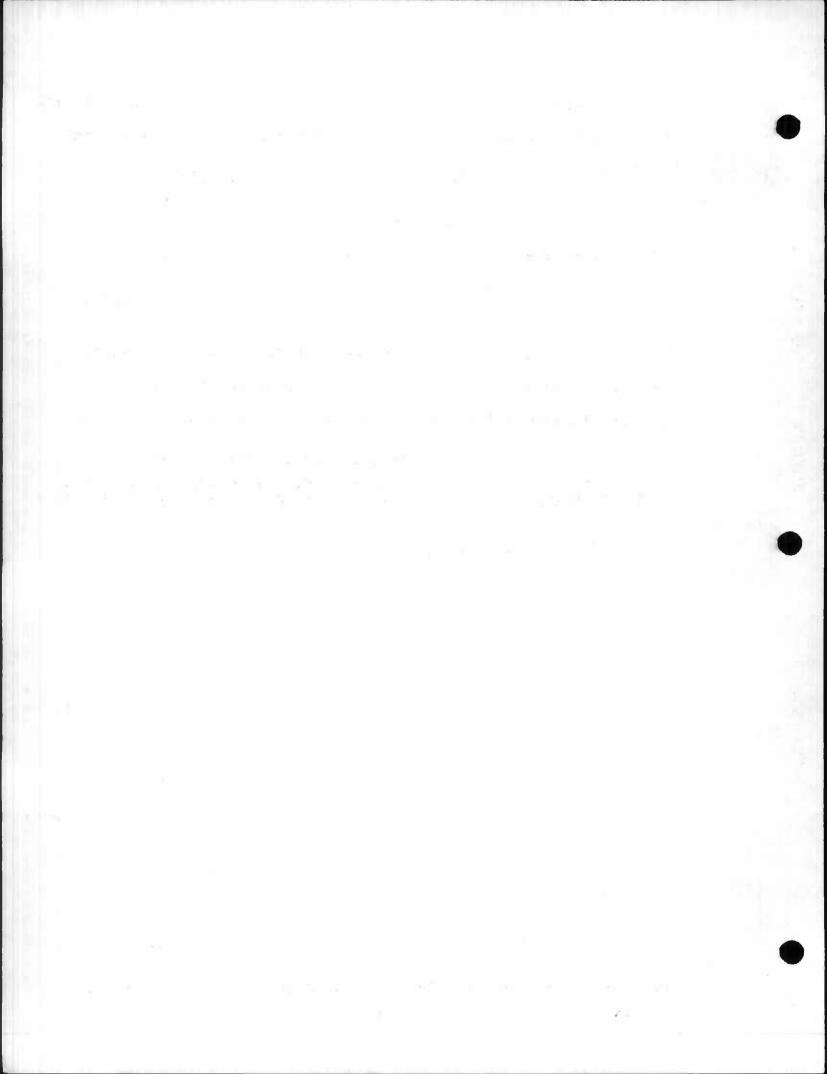
					Certi	ficate of	Death		Re	g. No.				
Physicia /Medic		1. Decedent's Name (First, Middle, Le Ruth M. DeSime							Dete of Death			Time of Death: 35AM		
Examin		4a. Facility Neme (If not institution, given Stella Maris					4b. City, Too Timot	wn, or Location	on of Death	4c. County Ba	of Death 1 t i mor	е		
uneral irector			Sex 7. Ag 1 □ M (2) F	e (In yrs. last bir 7 1		If Under 1 Yea Months Days			Date of Birth Month, Day, t 5, 1		9. Birthpiece Country) M d	State or Foreign		
show at at	_	10a. State 10b. County		10c. City, Tow			<u>.</u>					side City Limits		
Pall	ecto	Md NA Baltimore, Md.										Yes 2□No		
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	by	11. Marital Status  1 Never Married XXMarried  3 Wildowed 4 Divorced	12. Wes Decedent I Armed Forces? 1  Yes  X N If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					e - American Inck, White, etc.  White				
n natur	Completed	15. Decedent's E (Specify only highest gra	ade completed)		(Give kin	t's Usual Occu d of work don NOT use retir	e durina most	of working	1	16b. Kind of Bi	usiness/Industry			
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nerk	2													
Department of Health and Meni Important: If Itam 27 is marked any Injury or other traumatic a once.		19a. Informent's Name/Relationship ( Benedict J De	* .	sband	41	01 Ma					d. 212			
		20a. Method of Disposition  X1X Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Special			y, cremat	on (Name of ory or other pi eemer	,	01/		Location - City or Town, State altimore				
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sician edical miner	ler	23e. Penti. Eriter the diseese, or com shock, or heart failure. List only Immediate Ceuse (Finel disease or condition resulting in death)	BREA	ST CAN	CER						Inter	roximete vel Between et and Death		
n and el-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	Due to (or as a	(or as a consequence of):									
ling physicia e es the bur	Medical	Cause (Disease or Injury that initiated events resulting in death) Last												
E P	Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause										cause of death		
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58	Completed t								24a. Was an autopsy performed? 24b. Were eutops available priving completion of death?			prior to		
page page	Con								1 🗆 Ye	s 2 XNo	1 ☐ Yes	2□ No		
	Be	25. Was case referred to medical examiner?					28. Plece	of Deeth (Ch	eck only one	9)				
this ceral direction	2	examiner							5 Reside	nca 8 10 Oth	er (Specify) H	OSPIC		
To the Funeral Director: After t completely filled in by the funera	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b		Yeer) li	28b. Time of Injury at Work? 28d. Description 28d. Descri					escribe how injury occurred				
filled in b		4 ☐ Homicide determined  29a. Certifier 1 ☐ CertifyIng Ph		actory, onice  2di. Location (street and Number or Hural House Number, City or Town, State)  urred at the time, dete end place, and due to the cause(s) and menner es steted.										
pletaly filled	ledical	(Check only 2 Medical Examone)	niner: On the basis of and manner ste	examination and	dor invest	tigation, in my	opinion, deet	h occurred el	the time, da	ite and place,	and due to the	cause(s)		
comple	Σ	29b. Signature end the of certifier	7-			_	43725		29	,	d (Month, Day, 12/99	Year)		
Stat		30. Name end eddress of person who  DR • TARIO MA  31. Date filed (Month, Day, Year)		300 DU			LEY_R	OAD,	TIMON	NIUM,	MD 2	1093		

a.m.

4:35

JANUARY 12, 1999

RUTH DESIMONE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Month Dey , 1999 **Physician** 8:08AM January Rose Marie Ebacher /Medical 4e. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON BALTIMORE GREATER BALTIMORE MEDICAL CENTER 7. Age (In yrs. lest birthday) If Under 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 11/23/1938 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Months Hours 10 M 20 F Wisconsin 389-38-6101 60 Director Usual Residence of Decedant 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examiner nyant be notified at 1 Yas 2 No Directo Wisconsin Wisconsin Rapids Wood 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3021 13th St. South 54494 USA 12. Was Decedant Evar In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian, pemit. Peges 1 and 2 should be filed within 72 hours after. Department of Health and Mental hygiene. Important: If Item 27 is marked other than "naturel", or Itel any Injury or other traumatic event, the Medical Examinat Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas: 1 ☐ Never Married 2 Merried 1 ☐ Yas 2 ☒ No Specify: à Specify: 3 Widowed 4 Divorced White 15. Decedant's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) Accounting Tax Consultant Ebacher, 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Casper Huser Cecilia Kelly 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54494 19a. Informant's Name/Relationship (Type, Print) 3021 13th St. South Wisconsin Rapids, Wisconsin Ronald T. Ebacher 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Altdorf, Wisconsin St. Joseph Catholic Cem. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Liceosee 22. Nama and Address of FecilityRuck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, only one cause on each line. 23a. Part1. Entar tha disaase, or com shock, or heart failure List only Approximata Intarval Between Onsat and Death Physician Immediate Cause (Final disease or condition rasulting in death) /Medical Coma **Examiner** Examiner Civrhosis the attending physician end hed for use as the bunal-transit certificate be executed Sequantially list conditions, if any, leading to immediate ceusa. Enter Underlying Causa (Disaase or injury Physician/Medical that initiated events rasulting in daath) Last Due to (or as a consaguance of) 88 Part il. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. should be detached 23b. Did tobacco use contribute to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Wara autopsy findings available prior to completion of ceusa of death? 24a. Was an autopsy Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa referred to medicel axaminer? Be 26. Placa of Daath (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? After 5 Pending invastigation 1 Natural death. 1 ☐ Yas 2 ☐ No or Attendi efter death Director: A 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28a. Place of Injury - At home, ferm, straat, factory, office building, atc. (Specify) 4 | Homicide To the Hospital c within 24 hours of To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Cartifiar (Check only one) 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 22530 asson 113 1-10-99 30. Name and address of person who completed ceusa of daath (Itam 23a) (Type, Print) 120 sister Pierre Drive MAKHZOUMI HASSAN 31. Data filed (Month, Day, Year) 32. Registrar's Signatura JAN 14 1999

**DHMH 16 Rsv 6/95** 

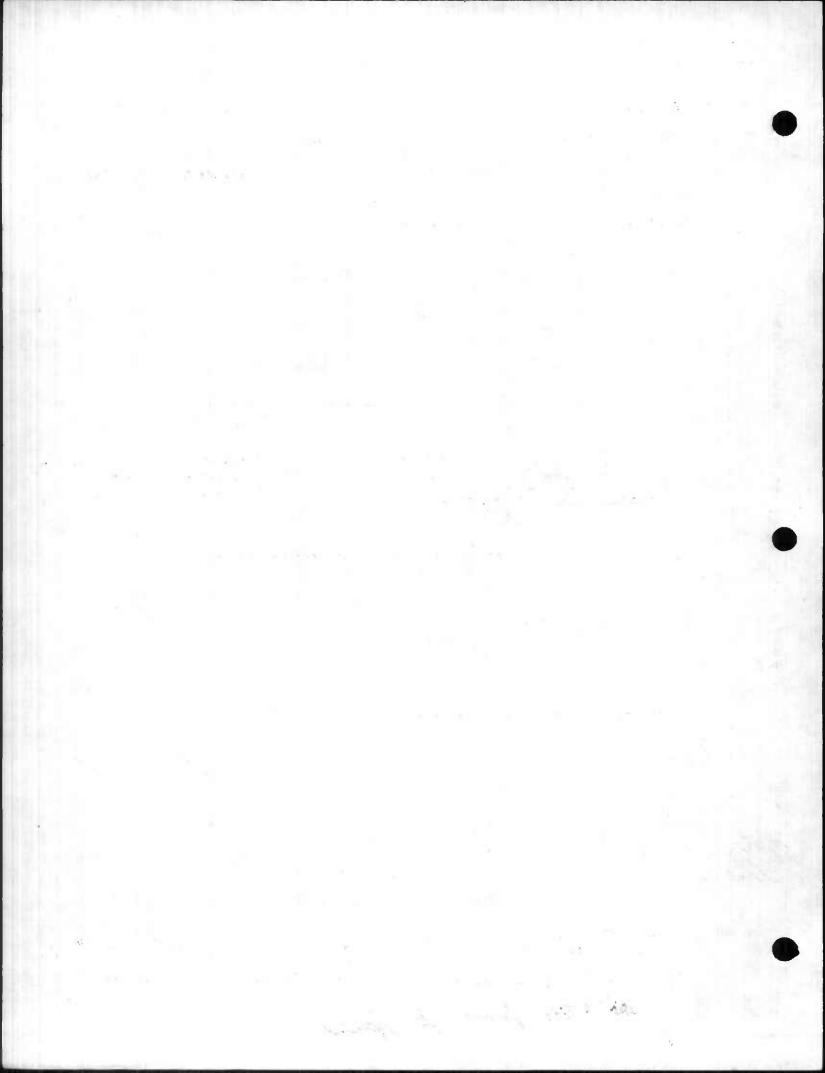
Registrar

**DHMH 16 Ray 6/95** 

State Registrar

30. Name and 0

32, Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Item 1 Per PHY FilmG767 1-14-99 Certificate of Death rja 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician EALTER Helen Falter HELEN January 5, 1999 3:40 AM /Medical 4c. County of Deeth Baltimore City 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Long Green Genesis Elder Care Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 212-01-1493 1□M 2₩F 84 Yrs. April 30, 1914 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inalde City Limits 28a-f show Maryland Baltimore City Baltimore 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 115 East Melrose Road 21215 U.S.A. Norma 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces?

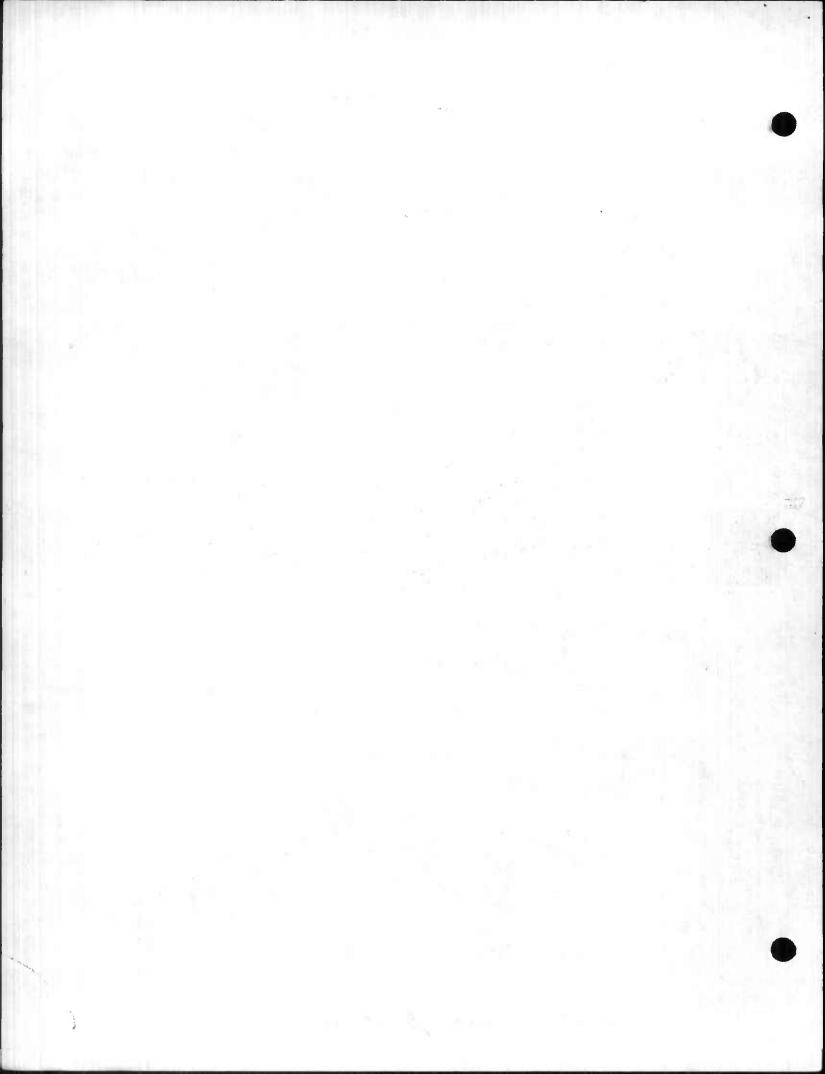
1 Yes, 2 No If Yes, Give X Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Bleck, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: White Specify: by 3 ⊠ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygieco. Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fire Department of Health and Mental Hy Important: if Item 27 is marked ofth any Injury or other traumatic event attack. 18. Mother's Neme (First, Middle, Maiden Surname) Be John Francis Falter Agnes Teresa Miller 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19e. Informent's Neme/Reletionship (Type, Print) 1094 Magothy Circle, Annapolis, Maryland 21401 Rosalie Juras, niece 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ⊠ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee Ronal d Sa Wards 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Director Mile Baltimore, Maryland 21201 That I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical Chrone Obstructure Examiner Due to (or as a consequence of): Examiner marmie physician and the burial-transit the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Gastro intertina Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): P.O. signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records. g 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 a 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to 25. Wes case referred to medical examiner? 8 26. Place of Deeth (Check only one) 1 Yes 2 70 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Offetural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide tel Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier MI) D 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHOA 113 A. HASHMI SLI W. Entry St Smtc 308; Balt. mp 2/201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

4 1999



Box 68760

P.O.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Dolores Shirley Haller 0230 JANUARY 1999 /Medical 12 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Augsburg Lutheran Home Randallstown Baltimore 5. Social Sacurity Number 218-26-6601 7. Aga (In yrs. last birthday) 68 Yrs. if Undar 1 Year | If Undar 24 Hrs. 8. Deta of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Hours 1□ M 2XF Director MAY 31, 1930 Maryland Usual Rasidanca of Decedent death with the Maryland 10c. City, Town or Location Baltimore Baltimore 10d, Inside City Limits 28a-f show the Medical Examiner must be nutified at Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ŏ 9500 Burton Avenue 21234 USA itams 23a Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yas 20 No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Navar Married 2 Married nd Mentel Hygiene. marked other than "natural", or 1 ☐ Yes 2 No Specify: by Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Oil Company 17. Father's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if Item 27 is marked oth any lighty or other traumatic event songs. 18. Mother's Name (First, Middle, Maiden Sumame) Be Clifford Harbeson Lavonia Engle 19a. Informant's Name/Relationship, (Type, Print) Linda L. Harding/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9500 Burton Avenue Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 1/13/99 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 ☐ Cremation 3 □ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Se 22 Cremation Fastociety of Maryland, Inc. McDohald Dawn 299 Frederick Rd. Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) METASTATIC LUNG CANCER 2 MONTHS **Examiner** Due to (or as a consequence of): Examiner ettending physician end for use es the bunal-transit The lew requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Denknown 1 Yes 2 No ADULT ONSET DIABETES MELLITUS Completed by page 2 should 24b. Were autopsy findings available prior to 24e. Wes en autopsy performed? HX OF GASTROINTESTINAL BLEEDING completion of cause of death? 1 Yes 2 No 1 Yes 2 Dino certificate Hospital or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Homa 5 Rasidenca 8 Other (Specify) 1 Yes 2 No Certification: To To the Hospital or Attending Physi within 24 hours after death.

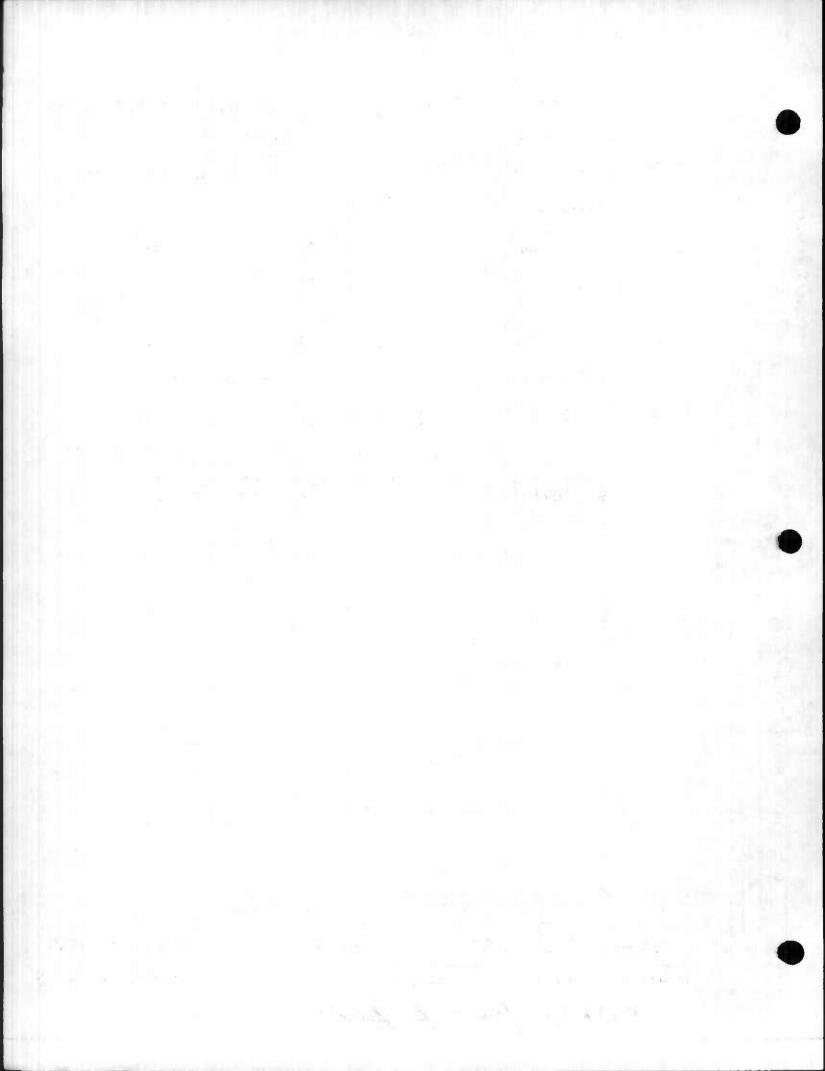
To the Funeral Director: After this of completely filled in by the funeral dir After this 27. Manner of Death 28c. Injury at Work? Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and mannar stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dierce H45931 January 12, 1999 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Deborah I Pierce DO 7aa0 Par 7220 Park Heights Avenue Baltimore MD 21208

State Registrar

JAN 1 4 1999

31. Date filed (Month, Day, Year)





State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1 Decedent's Nema (First Middle Last) 2. Dete of Death 3. Time of Death January 13, 1999 **Physician** Robert Lee Holston 12:40 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Irvington Knoll Baltimore Baltimore City 8. Dete of Birth (Month, Day, Year) Feb. 25, 1 If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** Months Deys Hours Min 1⊠ M 2□ F 219-16-1654 Yrs. 74 1924 Maryland Director Usual Residence of Dacedani the Maryland r 28a-f show a notified at 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits Maryland Anne Arundel Glen Burnie 1 Yes 2 No Directo 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number with 1 7 is marked other than "natural", or items 23s or treumstic event, the Medical Examiner must be a 109 Water Fountain Way 21060 United States pemit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hypiene. Important: If item 27 is marked other than "natural", or items 23a and Injury or other treumatic event, the Medical Examiner must obse. Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Race - American Indian 11. Meritel Stetus Black, Whita, alc. 1 ⊠ Yas 2 □ No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: Specify: þ WW II 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedant's Education (Spacify only highast grada completed) 16e. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elamantery/Secondery (0-12) Collega (1-4or 5+) Machine Operator Construction 18 Mother's Nama (First Middle Maiden Surnema) 17. Fathar's Nama (First, Middla, Last) Warren Holston Rosadell Gurney 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Typa, Print) Helen G. Holston / Wife 109 Water Fountain Way, Glen Burnie, MD 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Slata 20a. Method of Disposition January 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from State Metro Crematory, Inc. 14, 1999 Catonsville, Maryland 4 □ Domation 5 □ Other (Specify) 22. Nama and Addrass of Facility
Kirkley-Ruddick Funeral Home, P.A. 21. Signature of Funeral Service Licensee 421 Crain Hwy., S.E., Glen Burnie, MD 21061 a 23e. Part1. Enfer the disease, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. Approximata Intervel Batween Onset and Deeth **Physician** Immediata Causa (Final disease or condition resulting in deeth) /Medical Examiner Ma-Examiner Vas 2 500 sician and burial-transit certificate be axecuted Sequantially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disaasa or Injury that Initiated evants rasulting in death) Last Dua to (or as a consequence of) Box 68760. W/C attending physician for usa as the buria Physician/Medical Due to (or es e consequence of) ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 3 Probably 4 Unknown 1 Tyes 2 No signed t Division of Vital Records, by 24b. Wera autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed paga 2 hes 1 ☐ Yas 2 ☐ No certificata or Attending Physicien: director, 25. Was case refarred to medical axaminer? Be 26. Pleca of Deeth (Check only one) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28d. Describe how Injury occurred 28a. Data of injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Certification: 5 Panding invastigation 1. Natural efter death. Diractor: Aft 1 ☐ Yas 2 - No 2 Accidant 6 Could not be detarmined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - Al homa, farm, strael, factory, office building, etc. (Specify) 4 T Homicida 24 hours e Funeral C 29a. Cartifiar \*\*Cartifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to the ceusa(s) and manner as stated. edical 2 Medical Examiner: On the basis of axeminetion end/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner stated. (Check only one) within 2 the 29d. Date signed (Month, Dey, Year) 29b. Signeture end litle of certified 0 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) TAMED 501

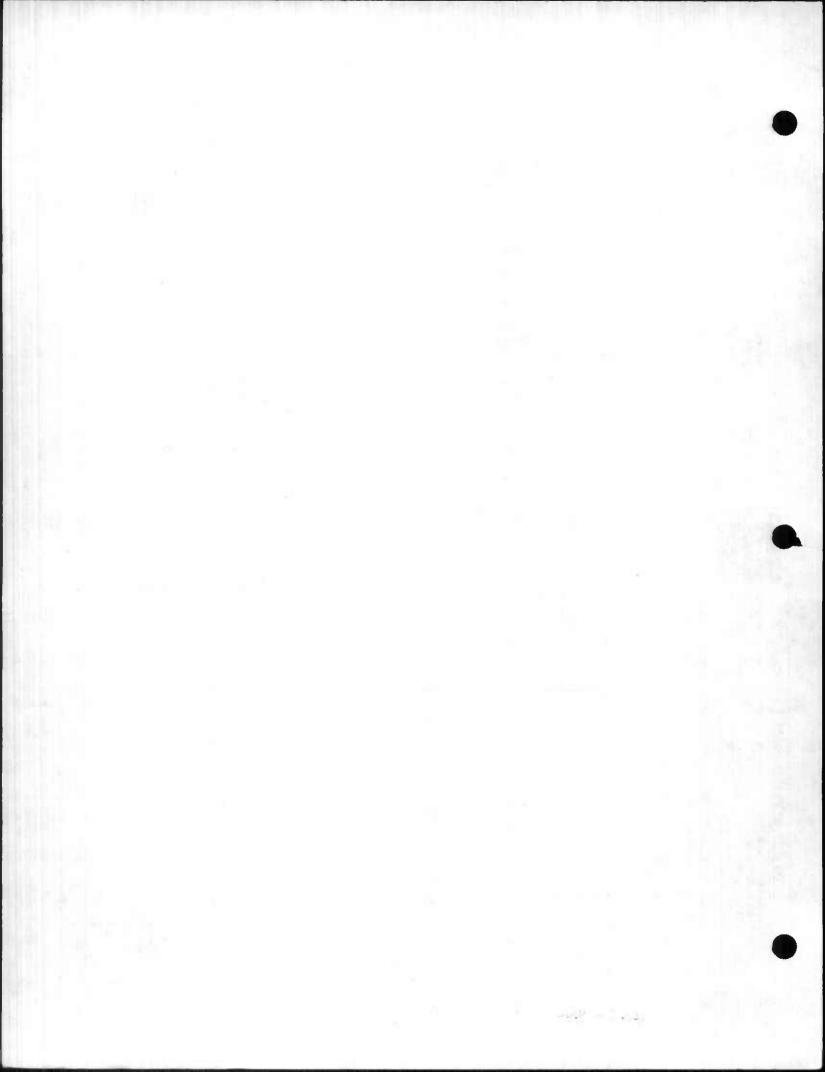
32. Registrar's Signature

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** JOHNSON CHARLES 1999 TANUARY 10:52 Am /Medical 4b. City, Town, or Location of Death-4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** LENTER H-SPIMZ ANDAUSTOWN BALTIMONE If Under 24 Hrs. ff Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (Stata or Foreign Country) 7. Aga (In yrs. last birthday) Hours 26 291 Months Usual Rasidance of Dacedant 10a. Stata 10d. tnside City Limits 10b. County 10c. City, Town or Location Marylow BALTIMUR Ansalls to wa Nas 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5/8 21/33 USA Carriotts 11/18 Funeral 12. Was Decedent Ever in U.S. Armed Forcas?

D Yas 2 □ No.
If Yas, Giva
Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Merital Status Black, Whita, atc. Nevar Married 2 Married WWII 1 Yas 2 No Specify: Specify Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) UNK. UNK. UNK. 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Father's Nema (First, Middla, Last) Be UNK. P 19b. Mailing Addrass (Street and Number or Ryral Routa Number, City or Town, State, Zip Code) 11/33 105/8 Marker offs UNE ROAD RAND Statemy My 19a. Informant's Name/Ralationship (Type, Print) (ARE BISHOP Edith Mongum Provides 1-92 20c. Location - City or Town, Stata 20b. Place of Disposition (Nama of cematary, crematory or other p 20a. Mathed of Disposition Dața Burial 2 Cremetion 3 Ramovat from Stata Coreneville, Marylons 16 Leksons Concern Correne Mile Marylows 22. Nama and Address of Facility AATMAN ARKES Finesal Home rounsulle 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Service Licensee 23a. Pert / Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haen failure. List only one cause on each line. Approximata Intarval Between Onset and Death tmmediata Causa (Final CARDIOGENIC 2 Hours disaasa or condition rasulting in death) Dua to (or as a consequence of): Examiner INFARCTION MYOCANDIAL 2 HOURS Sequantially list conditions, if any, leading to Immadiata cause. Enter Underlying Cause (Disaese or Injury that initiated avents rasulting in death) Last Dua to (or as a consequence of): ANEMIA SEYERE Physician/Medical Dua to (or as a consequence of) DA 45 BLEED Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was casa rafarrad to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 Yes 2€No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28h Tima of 28c. Injury at Work? Naturat 5 Pending invastigation 1 Yas 2 No 2 Accidant 6 Could not be datarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida edical 10 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Certifia

Box 68760. P.O. Records, Division of Vital Attending **Funeral** 

**Director** 

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permit. Pege Department of Important: If eny injury or pace.

**Physician** /Medical

Examiner

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980

Baitimore, Maryland 21215-0020

State Registrar **DHMH 16 Ray 6/95** 

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To the Funeral Director: A
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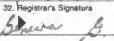
29b. Signeture end title

Roberg

the Hospital

31. Data fited (Month, Day, Year) JAN 1 4 1999

30, Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)



540)

29c. License number

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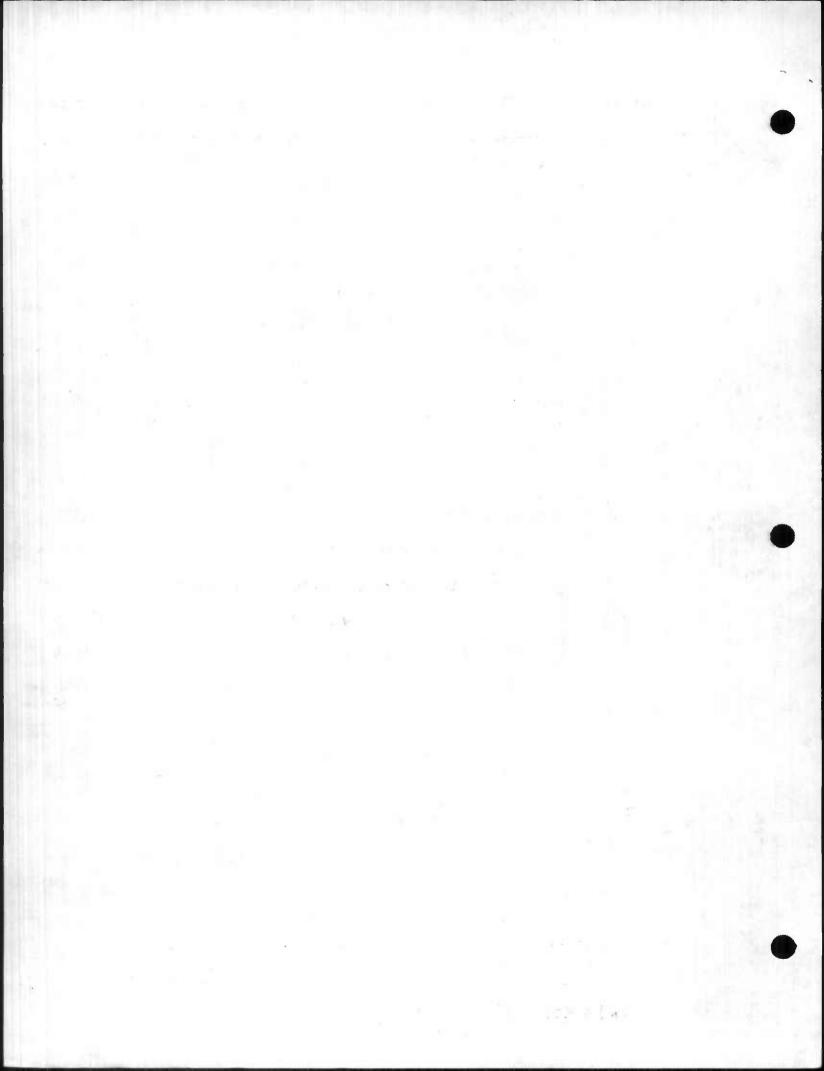
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29d. Data signed (Month, Day, Year)

RANDALLS TOWN, MD 21133

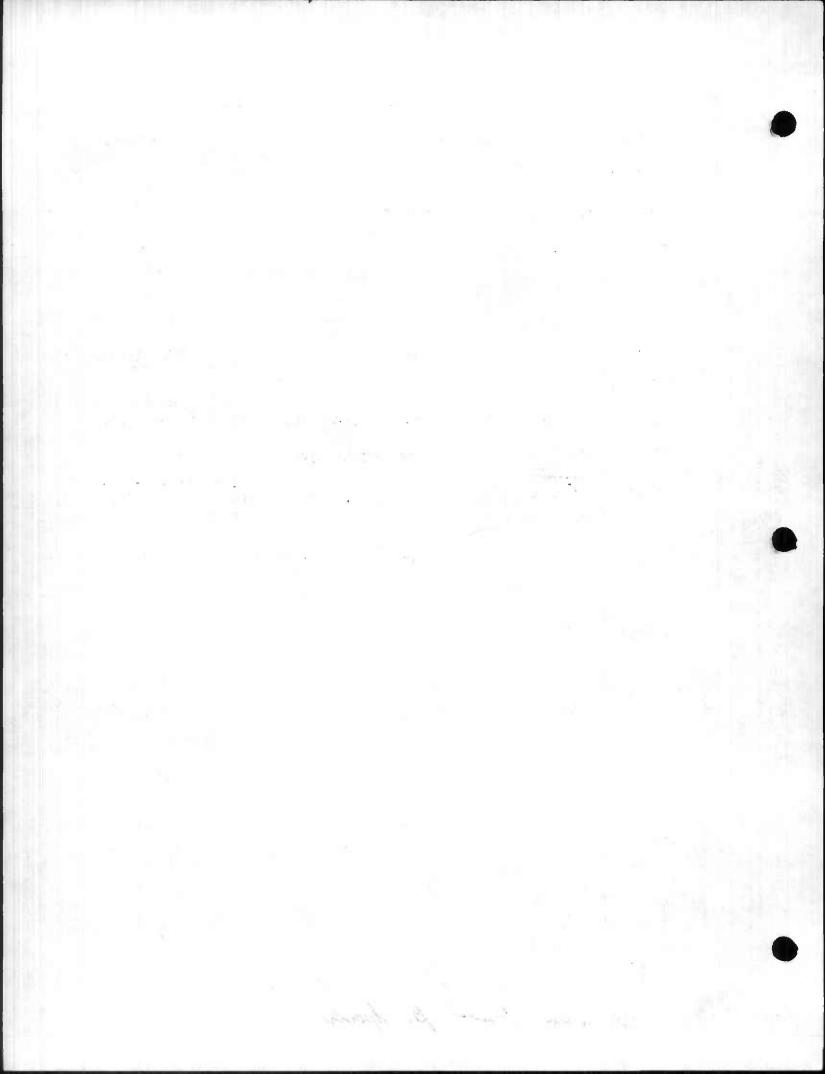
TANUARY

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					Cei	rtificate of	Death		Reg. No.			
n 1. D	ecedent's Name	(First, Middl	le, Last)		KADIS	SH SH		2. Date of D Month JANUA		OOO	3. Time of Death 7:15 PM	
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5. Sc	ocial Security Nu	ımber	6. Sex 1 ☐ M 2 🗓 F	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hi	s. 8. Dete of B			ace (State or Foreign ry)	
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	State	10b. County		10c. C	ity, Town or Lo	cation				10	d. Inside City Limits	
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E	lementary/Secon			(1-4or 5+)	life. I	OO NOT use retire	d)					
17. [	12 Father's Name (/	First, Middle.	Last)		OWNER		18 Mother's N	ame (First, Middl	RETAIL e, Maiden Sumai		DASHERY	
	LAWRENC				UBFAL	L	RIVKA			TAINA	RLE	
19a	. Informant's Ne	me/Retetions	ship (Type, Print)		19b. Meitir	ng Address (Street	t and Number or I	Rural Route Num				
			rsch / Da			ARBORWOO	D ROAD -	- BALTIM	ORE, MD	2120	8	
		Cremetion	3 Removel from	n State	cemetery, cren	sition (Name of natory or other pla		Date	20c. Location			
	4 □ Donation :			BA		HEBREW		1/13/9	9 REIST	ERSTO	WN, MD	
21.	1/0	int	76			900 REIS	2		NSON & B		INC. MD 21208	
Imm	nediate Cause (Fasse or condition ulting in death)	inal	e	Due to	hy Dro	uence of):	Seps,	ac or respiratory	arrest,		Approximate Interval Between Onset and Deeth  1-2-days	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or es a consequence of):  Due to (or es a consequence of):  d											ane	
Part	II. Other signific	ant condition	one contributing to	death but not re	sulting in the u	ndertying cause git	ven in Pert I.	23b. Did	d tobacco use co	ontribute to	the cause of death	
	In the underlying cause given in Pe							- 10	Yea 25000	3 Prob	ably 4 Unknow	
			1-1-1	Shire					s an autopsy formed?	eva	re autopsy findings ilabte prior to apletion of cause leath?	
	4				3-1-1			1	Yes SONO	1 🗆	Yes 2□ No	
•	Wes cese referre		Hospital:	21	2500	Ott	hor -	eeth (Check only				
27. N	Ves 2001 Vanner of Death		28a. Dat	e of Injury	28b. Time of	3 DOA	SUNUrsing	Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred				
3	Naturet Call Accident Suicide Under Homicide	5 Pendir investi 6 Could determ	getion not be	onth, Day Year)	Injury		Yes 2 No		28I. Location (Street and Number or Rural Route Number, City or Town, State)			
	. Certifier	Cortifyin	g Physician: To th	ding, etc. (Spec	owledge, death	occurred at the ti	me, date end pla	ce, end due to the	e ceuse(s) end m	enner as st	nted	
	one)	_	Examiner: On the and me	nner steted.	etion and/or in			curred at the time				
001	Cinemaker -					29c. Licens	se number		29d. Date signi	ea (Month, L	Jay, Year)	
29b.	Signature and	wer or contino	) -			7	- 110		- /	10-		
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 4:50pm JANUARY 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE BALTIMORE SAMARITAN HOSPITAL 7. Age (In yrs. last birthday) if Under 1 Year 5. Sociel Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 1□ M 2□ KF 215-24-0129 Aug. 16,1905 Virginia Usuei Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2√2 No Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8710 Emge Road 21234 United States 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yas, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 ⊠ Widowed 4 □ Divorced White 15. Dacadant's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Years Homemaker Own Home 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Worrell Mary Agnes Bowler 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) Catherine Sibiski/Daughter 7356 Manchester Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other plece) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ~ ☐ Other (Specify) Bohemian National Cem. 1/13/1999 Baltimore, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter the disease, or complications that caused in shock, or heart feilure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Betw Immediate Causa (Final SEPSIS disease or condition rasulting in death) Dua to (or as a consaquance of) Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that Initiated avants resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? Fibrillation 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 DNo 1 Yes 20 No 25. Was case raferred to medical 26. Place of Death (Check only one) 1□ Yes 2□ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datarmined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 Sulcide

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

Be

10a State

**Funeral** 

Director

other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at

filed within 72 hours after

Hygiene.

Peges 1 end 2 should be file tment of Health and Mental Hi tant: If them 27 is marked oth

nt of Health a : If from 27 is or other trac

Department of Important: If any injury or

21215-0020

Baltimore, Maryland

Examiner the buriel-transi and Physician/Medical sate has been signed by the ettending page 2 should be deteched for use þ Completed this certificate Be Certification: To After death.

or Attanding Physician: The law requires that the death certificete be executed Box 68760. P.O. Division of Vital Records, Director: To the Hospital within 24 hours e

State Registrar

Medical

30. Name and odrass of person who complated cause of death (itam 23a) (Type, Print)

RESIDENT

29c. License number P12559 29d. Dete signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Dr. SAMUEL FRIMPONG, G.S.H. 5601 LOCH RAVEN BLUD, BALTIMORE MD 21139

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Yaar)
JAN 1 4 1999

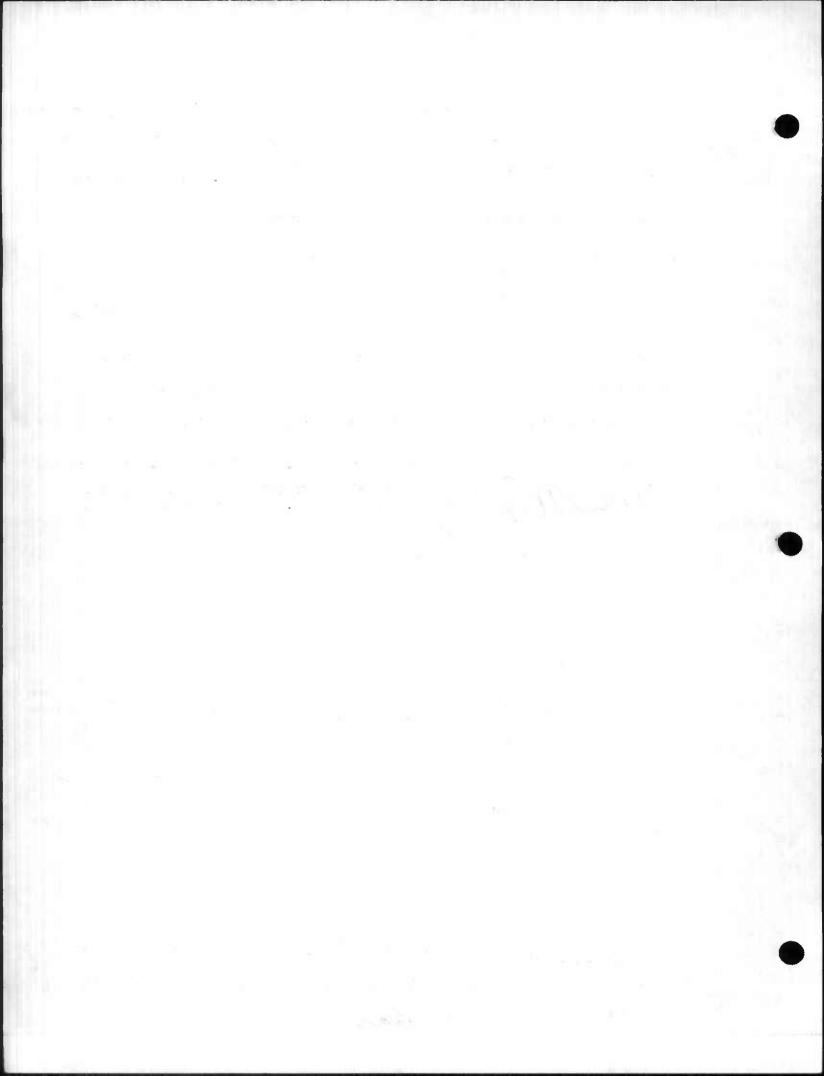
29b. Signature and title of certifier

4 | Homicide

(Check only one)

29e. Cartifiar

32. Registrar's Signature



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Margaret Ellen Laupheimer JANUARY 3 1999 6:20 am /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) \_\_\_\_ If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 1 F Months Days Hours 219-10-3536 Nov. 30, 1909 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Baltimore Cockeysville Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Beehive Place 21030 U.S.A. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specity: White λq 3√E Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Charles Rawlings Reed Anna Ellen Adkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) June Horner/daughter 5710 French Avenue, Sykesville, Maryland 21784 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility Ronald S Director Wade State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part I. Enter the disman or completions that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, back, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) ACUTE MI 10 minutes Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? HYPONATIZIEMIA ANEMIA 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Wes en autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 No 25. Was cese referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation Natural 2 Accident 1 Yes 2 No 6 Could not be determined 28f. Location (Streef end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signeture and title and artiful 29c. License number 29d. Date signed (Month, Dey, Year) ATTENDING nd eddress of person who completed cause of deeth (Item 23e) (Type, Print) 10753 FALLS MD. LUTHERVILLE, MD 21093 DAVIS G. PABERTS, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 14 1999

Registrar

**Funeral** 

Director

7 is tranked other than "natural", or items 23e or 28e-f shov traumstic event, the Medical Examiner must be notified at

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permit. Pages 1 and 2 should be file.
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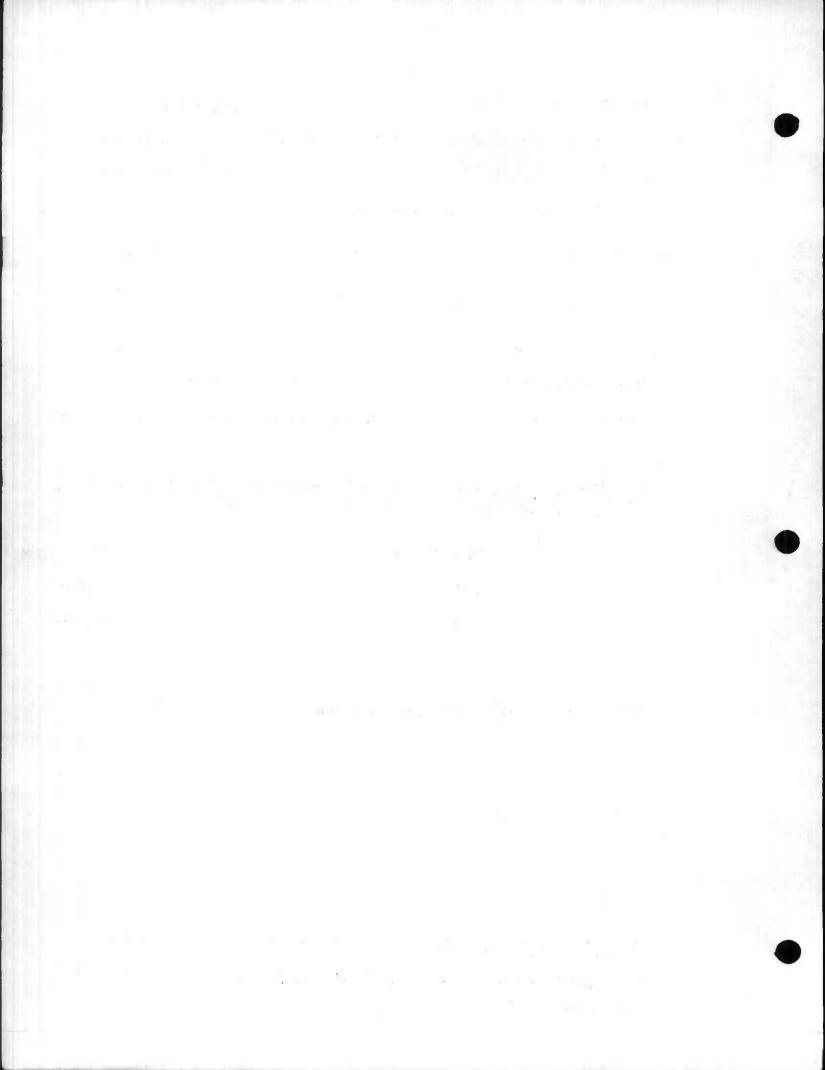
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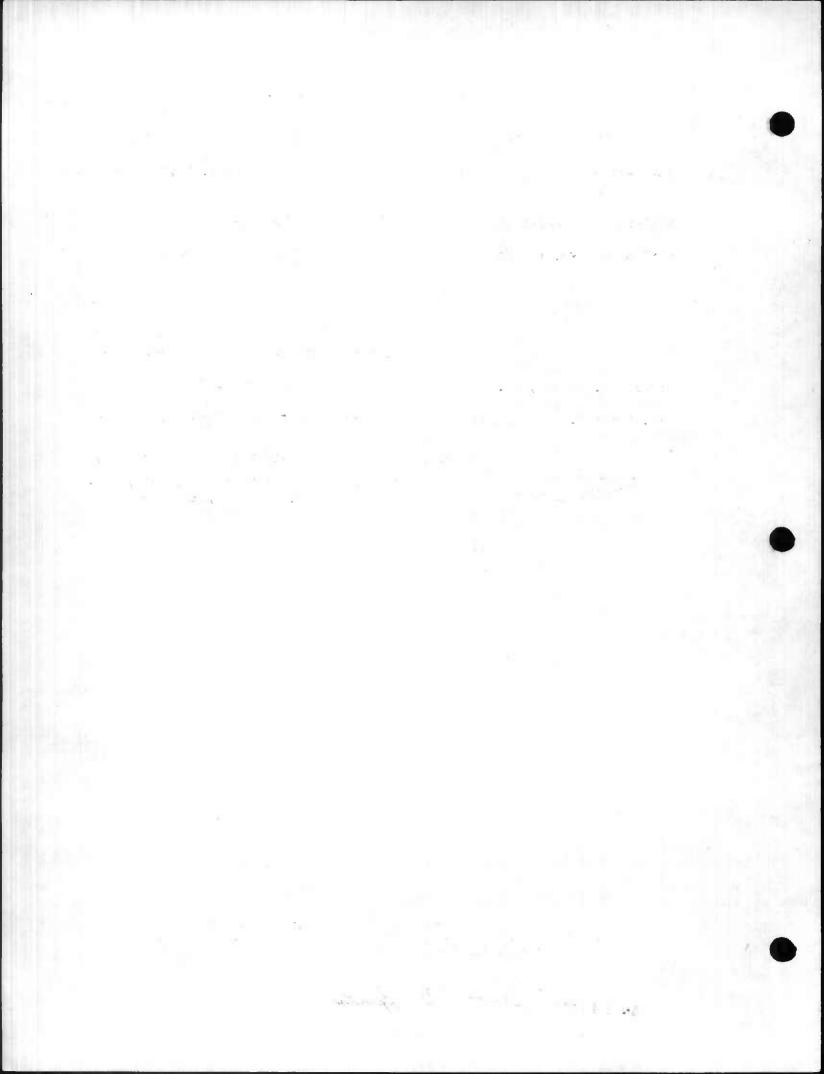
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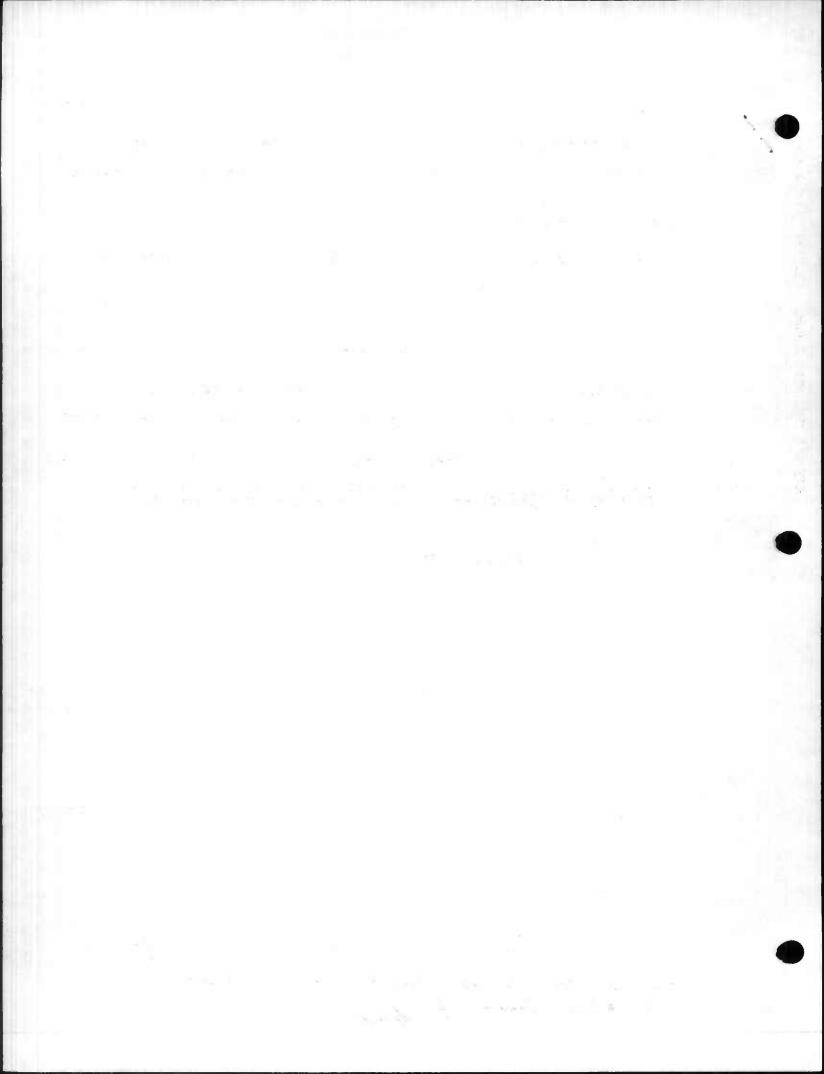
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death William Roger Morton, Sr. Month Year **Physician** 11:07 AM January, 9,1999 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8135 Murray Point Road Dundalk Baltimore ff Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 11XM 2□ F Yrs. Director 10,1941 214-40-1138 Sept. Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rithen "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at 1 TYPS 2X No Director Dundalk Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10a. Street and Number 21222 United States 8135 Murray Point Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Dacedent Evar in U,S. Armed Forces? 14. Raca - Amarican Indian, Black, White, etc. filed within 72 hours after Yes 2 No Yes, Give 1 ☐ Never Married 2 ☑ Married altimore. Maryland 21215-0020 1 Yes 2 No Specify: Specify: P 3 ☐ Widowed 4 ☐ Divorced White Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien important: if fem 27 is marked other that any Injury or other trainments. Railroad Engineer Railroad 12 Years 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Shirley E. Smith William A. Morton, Jr. 19a. Informent's Neme/Retetionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 8135 Murray Point Road Dundalk, Maryland 21222 Mrs. Lynda C. Morton/Wife 20b. Place of Disposition (Neme of 20a. Mathod of Disposition Date 20c. Location - City or Town, State ¥⊠ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 1/13/1999 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heer feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner certificate be executed and Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): physician P.O. Box 68760, Physician/Medical the Due to (or as a consequenca of): attending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by 1 Yee 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings available prior to Completed 24a. Wes en autopsy performed? been: completion of causa of deeth? page 2 s 2 No 1 Yes 2000 1 Yes certificate Division of Vital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Affer 1 Netural 2 Accident 5 Pending investigation death. 1 Yes 2 No Director: 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, fectory, office building, etc. (Specify) after 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signardy and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) me and eddress of person who completed cause of deeth (Item 23a) (Type, Print) N3250 0415 0 07 0 31. Date fited (Month Dex. 1999 BE Bogistrar's Signat State Registrar



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	State of Maryland / Department of Ho	ealth and Mental Hygiene	U	J		1

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**Physician** 

/Medical

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**Director** 

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Baltimore, Maryland 21215-0020

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29a. Certifier

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29b. Signature and of oertific

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HOUSCH 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Dey, Year) 12/99

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# P.O. Division of Vital

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**Physician** 

/Medical

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**Funeral** 

Director

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**Physician** /Medical

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Baltimore, Maryland 21215-0020

State Registrar

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29b. Signature and title of cartifier

32. Registrer's Signature JAN 1 4 1999

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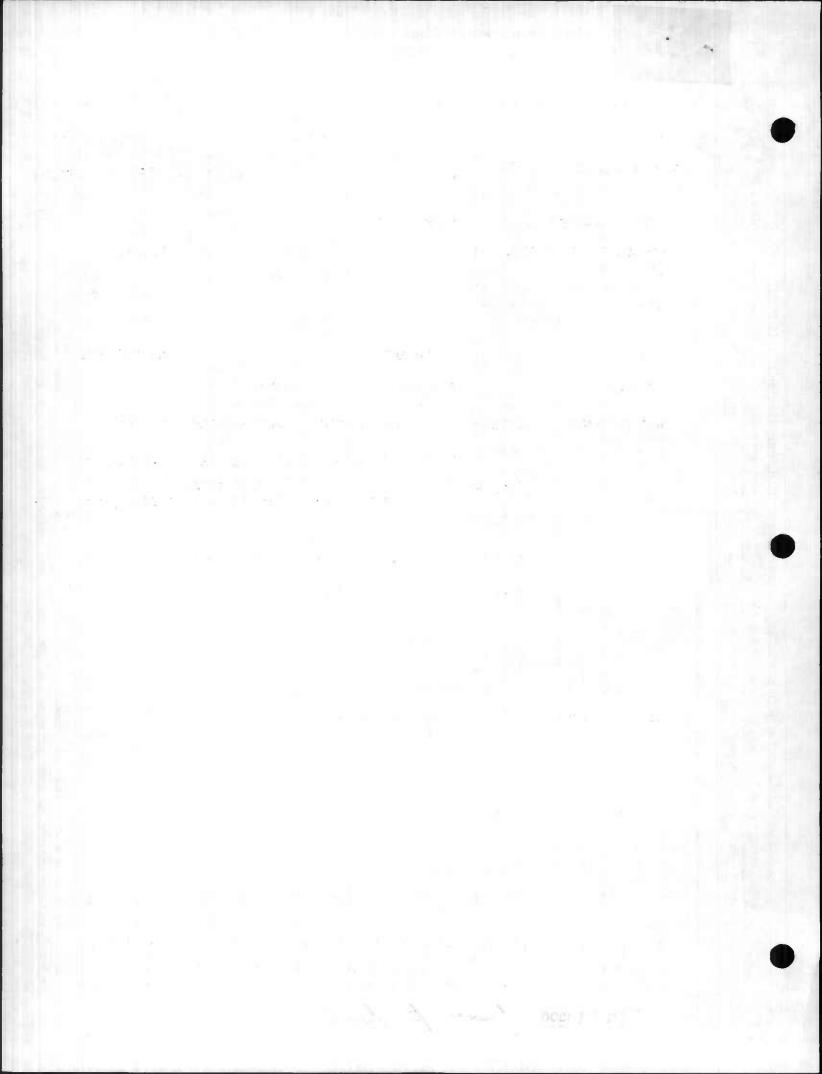
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 1 . S . 12 A . 11 . 10 . MORTH WEST HOSPITAL CENTER RANDALLSTOWN, MID

29c. License number

1243462

29d. Dete signed (Month, Dey, Year)

11,1999 JANUARY



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month 7:304.4 Georgia Patricia Marvin 12,1999 Jan. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death AGNES Hosp.400 CALON S. BAITIMORE
MUnder 24 Hrs. 8. Date of B 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) NOV • 11 1927 Birthplace (State or Foreign Country) Months Days 10 M 20 F Hours Min. 220-20-0184 Maryland Usual Residence of Decedent 10s. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3207 Bryant Avenue 21.227 United States 12. Was Deceden! Ever in U,S. Armed Forces? 1 | Yes 2 20 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Alexander Ewart Lillian Loretta Newell 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Cindy Powell ( Daughter ) 210 Cedar Dr. Glen Burnie, MD 21060 20a. Method of Disposition
1 Burial 2 Cremetion 3 Removel from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Baltimore National Cametery 4 ☐ Donation 5 ☐ Other (Specify) 1/15/99 Catonsville, MD 22. Name end Address of Facility Ambrose Funeral Home of Lansdowne 21. Signature of Funeral Service Licensee 2719 Hammonds Ferry Rd. Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the dealtr. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset end Death Chronic Immediate Cause (Finel disease or condition resulting in death) lucouth Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? mellitrer 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year)

**Physician** /Medical Examiner

Physician

/Medical

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by

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filed within 72 hours after death with the Maryla. Hyglene. Whyther than Insture!, or frems 23s or 28s-4 show that the besides Estimates must be promise.

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Physician/M Completed 2

Division of Vital or deeth. Irector: A In by the f To the Hospital within 24 hours a To the Funeral Completely filled

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Registrar

29c. License number D0052746

1 Yes 2 No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jan. 12, 1999 se of death (Hem 23a) (Type, Print)
720 Maidar Choice Lare #C Balt 21228

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

Theree

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 | Homicide

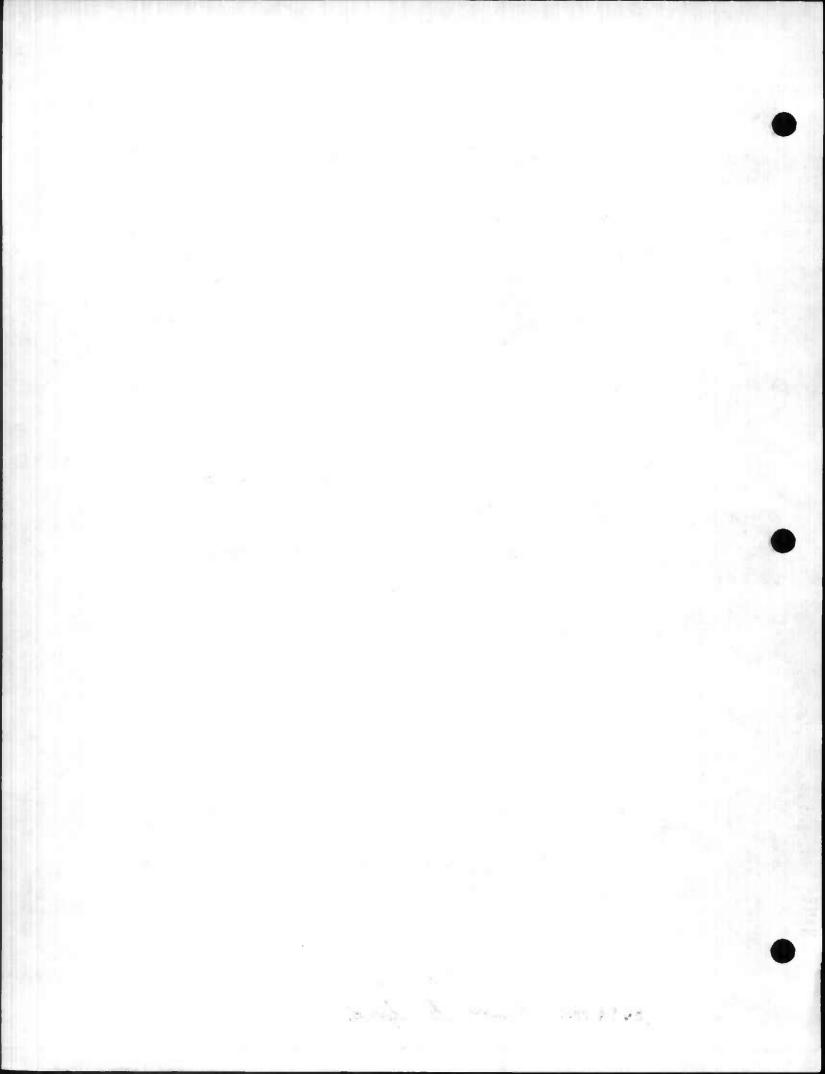
JAN I 4 1999

5 Pending investigation

6 ☐ Could not be

32. Registrar's Signetyre

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month : 45pM INOMAS LEE JAn 4a. Fecility Name (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Death maris BP/HMUE 10W562 If Undar 1 Yaar 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 24 Hrs. 9. Birthplece (State or Foreign Country) Deys Hours M 20F 217-56-5125 Yrs 5 Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORG 1 Yes 2 No 4614/040 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 21217 nc 10 h U513 Wes Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indien, Black, White, etc. 1 Nevar Married 2 Married 1□Yes 2No Black 3 ☐ Widowed 4 Divorced 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry PRIVATE Elementery/Secondary (0-12) College (1-4or 5+) DRIVER 12 YEARS 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) EULA JUNNSON 1 AMES Page 19e. Informent's Nema/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Gist AUE BA/HMUSE, Mary/Ans 21215 HELESTINE BElton SISTER 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other p 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Provisville Veteran Coneky 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nema and Address of Fecility PLA ATMAZ- HARR 15 21. Signeture of Funeral Sarvice kipensaa 5240 REISTERSTURN RUAN BANTHURE, Mary/AND 21 Mary pro 21211 23a. Party Enter the diseasa, or complications that causad the deeth. Do not antar tha mode of dying, such as cardiac or respiretory errest, shock, or heart feilura. List only one cause on each line. Approximete Intervel Batwaen Onset and Deeth Immediate Ceuse (Finel TONGUE CANCER diseese or condition resulting in death) Due to (or es a consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Last Due to (or es e consequence of) Dua to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en autopsy performed? 1 ☐ Yes 25 No 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 \ Homicide

P.O. Box 68760. THOMAS PAGE Records, Division of Vital

Physician/Medical Completed by Be 2 Certification:

Physician

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Director

Funeral

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**Funeral** 

Director

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Baltimore, Maryland 21215-0020

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**Physician** /Medical

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8, 1999

JANUARY

bunial-transit be axecuted and physician the 98 attending 50 signed by the a page 2 s certificate or Attending Physician: director. this After death. To the Hospital or Attendition within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

Medical

29b. Signatura and title of certifie

1 X Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted.
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the ceuse(s) and menner stetad.

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

TARIQ MAHMOOD, 2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093

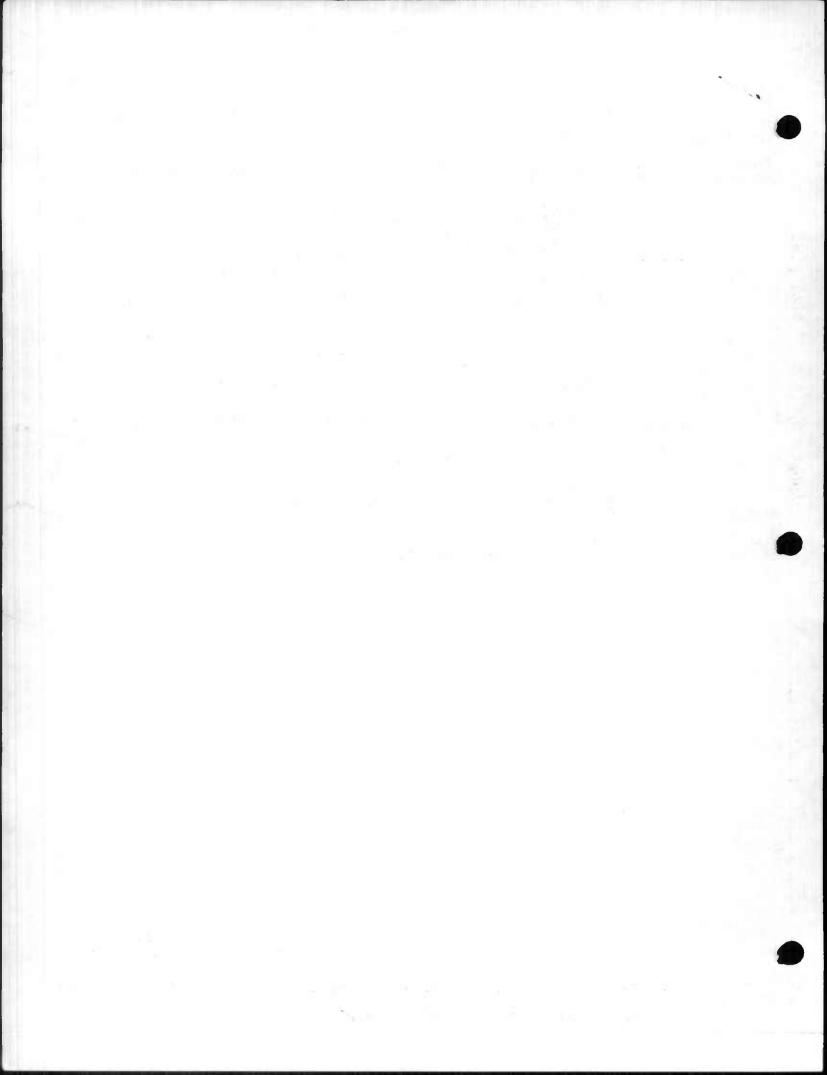
31. Dete filed (Month, Day, Year)

29a. Certifier

(Check only one)

JAN 1 4 1999

32. Registrer's Signetura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Vest Mary Parisi 99 4:20 am 14 Jan 4e. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth If Under 24 Hrs. Hours Min. MAR 27, 1921 Baltimory Center Charlestown Care if Under 1 Year 9. Birthplece (State or Foreign Country)
New York 5. Sociel Security Number 7. Age (In yrs. lest birthday) Sex 1□ M 2EF Months Deys 068-12-1695 77 Yrs Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Severna Park 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 331 Preswick Way 21146 USA 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Domestic 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Peter Bruno Phyllis Sciluffo 19e. Informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Donald J. Parisi/son 331 Preswick Way Severna Park, MD 21146
Dete 20c. Location - City or Town, Stete 20e. Method of Disposition

1 ABurial 2 Cremetion 3 Removel from Stete 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 4 ☐ Donetion 5 ☐ Other (Specify) Ferncliff Cemetery 1/19/99 Hartsdale, NY 22. Name end Address of Fecility
MacNabb Funeral Home, P.A. 21. Signeture of Fureral Service Licansee Bawn F McDonald 301 Frederick Road Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Cause (Final Mouths d Stage for Due to (or es a consequence of): Renal disease disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 16 3 Probably 4 Unknown 24b. Were autopsy findings evaliable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 DNo 1 Yes 2 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) examiner? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident

PARISI Vital Records, MARY VAME

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> State Registrar

**Physician** 

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**Physician** /Medical

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the Maryland

(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56051 January 14, 1999

1 🗹 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end manner as stated.

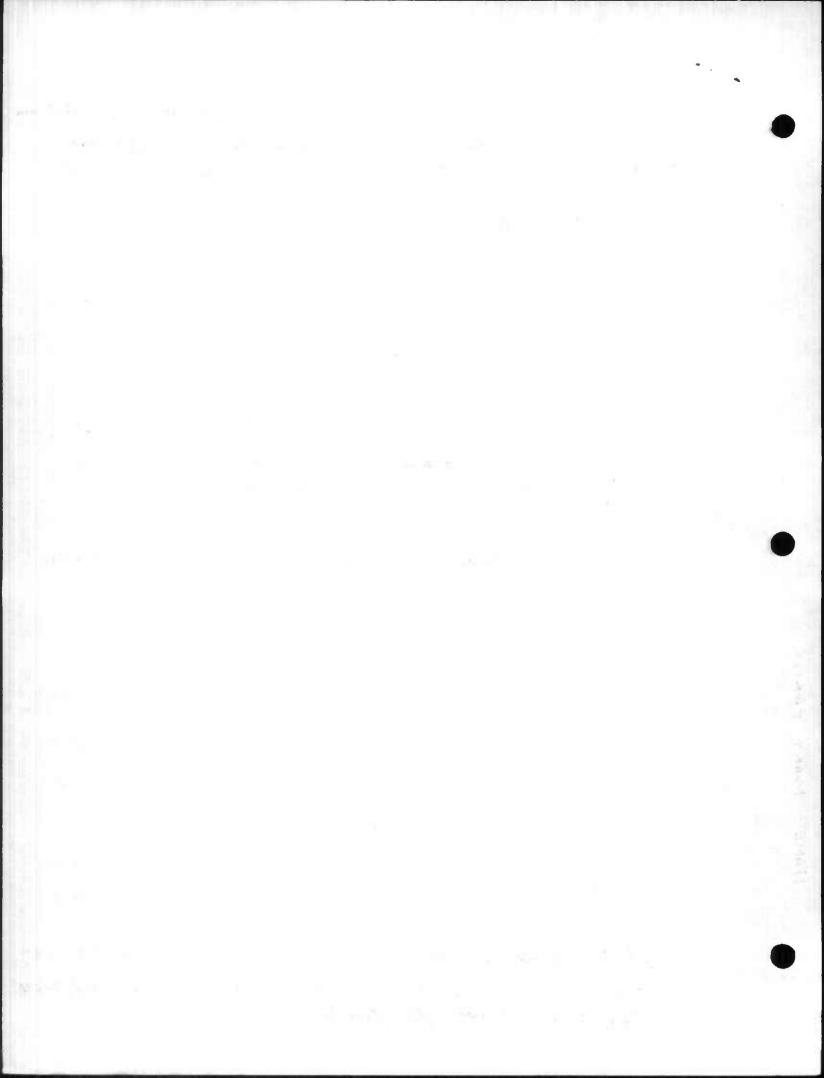
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

30. Nemg end address of person who completed cause of deeth (Item 23e) (Type, Print)

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32, Registrar's Signeture Maiden choice Lane, Cutonsville, MD, 21228 Middles 5a 31. Dete flied (Month, Dey, Year) 5alazar

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

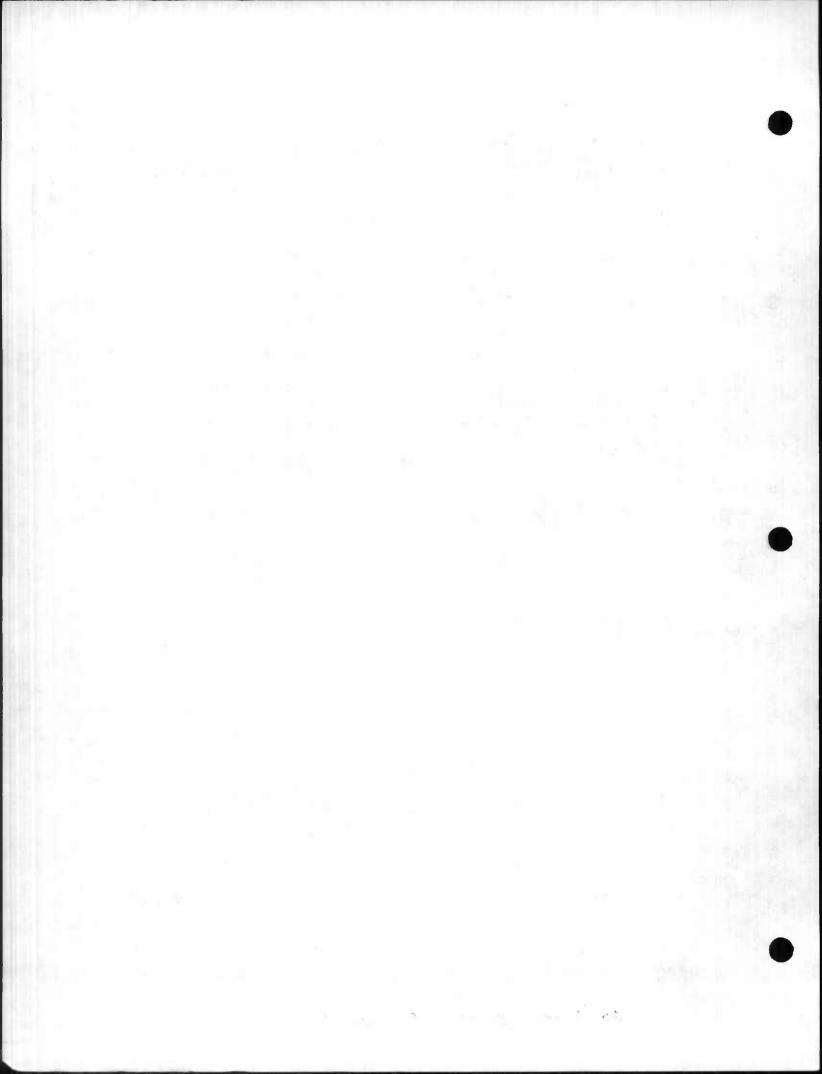


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State of Maryland / Department of Health and Mental Hygiene 9 9 0563

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Funeral	Social Security Number     6. S	ex 7. Age (In yrs.	Mc	Under 1 Year onths Days	If Under 24 Hrs Hours Min	(Month, Day,	Year)	9. Birthplace	a (State or Fo	reign
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T THE	19a. Informant's Name/Relationship (		19b. Mailing Ad	ddress (Street a)		ural Route Number,	-		ode)	
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d for use	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the under	hina causa aiva	n in Part I	23h Did to	bacco use con	tribute to th	a course of d	esth?
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= E	27. Manger of Death	28a. Date of Injury	28b. Time of	28c. Injury		28d. Describe ho				-
th.	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		es 2 No					
after death.  Director: After I in by the fune ertification	3 ☐ Suicide 6 ☐ Could not be	289. Place of Injury - At h	ome, farm, street, f	factory, office			reet end Numbe	er or Rural R	oute Number,	
al Director: After t led in by the funeral Certification:	4 Homicide	building, etc. (Special	fy)			City or Town	, State)			
on filled	29a. Certifier 1 Certifying Phy	vsician: To the best of my kno	owledge, death occ	urred at the time	, date and plac	e, end due to the ca	use(s) end mar	nner es state	ed.	
To the Funeral Director: After completely filled in by the funeral Medical Certification	(Check only 2 Medical Examone)	Iner: On the basis of axamina and manner steted.	ation and/or investig	gation, in my opi	nion, deeth occ	urred at the time, da	ite end placa, a	and due to the	e cause(s)	
To the Fu completel	29b. Signature and title of certifiar			29c. License	number	25	9d. Date signed	(Month, De	y, Year)	
> - 0	> 5 (1 a	nul		DS	0641	1	1th Jan	nuary	199	9
	30 Name and address of parent into	completed course of death fin-	m 23a) /Tunn Daint		· ·	V. Eura		00	m. e. t = A	0
	30. Neme and address of person who o	ABAPATIL	1 (11 7	- 30F	8211	V. Eum	W ST.	BAL	IINOF	0
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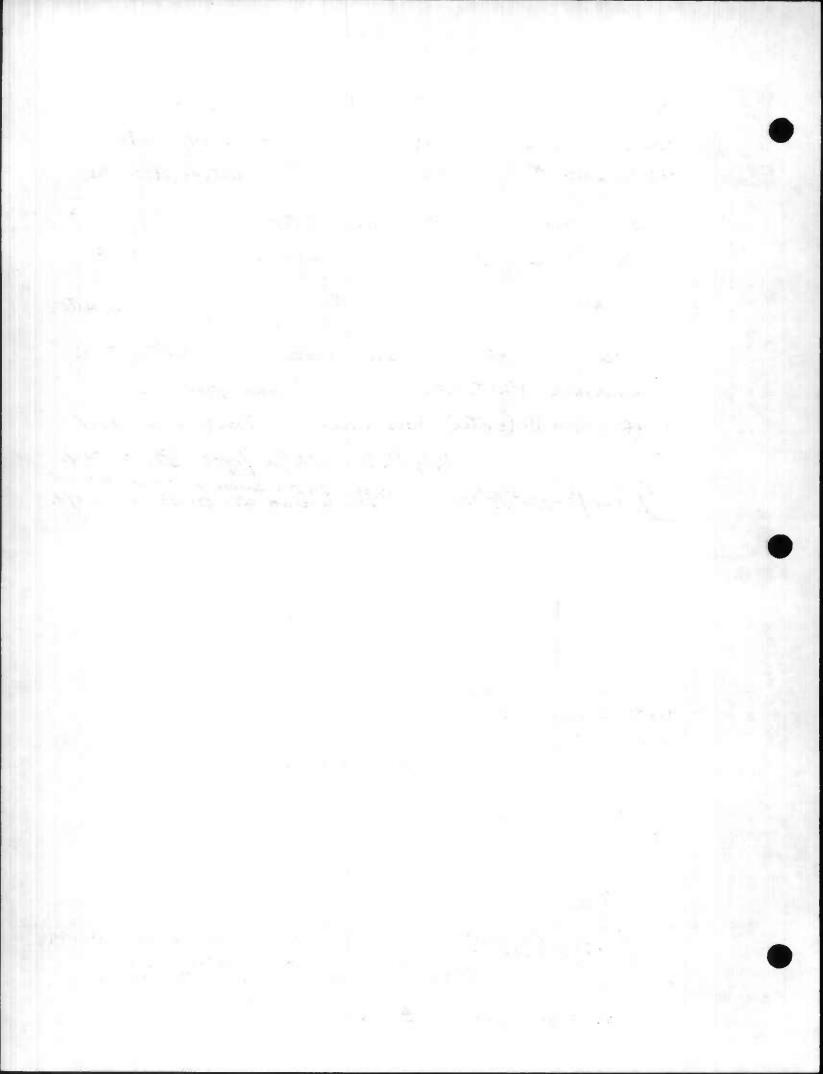
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death PLATEMOTE Month 7 20 PM **Physician** VINCENT 1919 More /Medical 4a Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BACTIMORE CITY

If Under 24 Hrs. 8. Date of Birth GOOD SAMARITAN HOS PITAL If Under 1 Year 6. Sex 128 M 2□ F 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** Months Deys Hours Min 65 212-30-2310 Usual Residence of Dacedant Yrs. MD **Director** with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at 1 PYes 2 □ No Director BALTIMORE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death vibrantiment of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical and any entire or other traumatic event, the Medical and any entire and any entir USA 1012 21202 Funeral ST 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritei Stetus Black, Whita, etc. 1 Yas 2 No If Yes, Give Yaar or Datas: 1 Never Merried 2 Married 1 ☐ Yas 2 ☐ No Specify: by 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highast grede completed) 16e. Decadant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) BRICKLAYER CONTRUCTION NIA 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be 10 PLATEROTE MARTUCCI ASQUALE LARA 19e. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) SISTER Los office GiorGilli 20a. Method of Disposition Bouto. 21202 74 ef 1012 ST. F AWN Place of Disposition (Name of cometery, cremetory or other place) Dete 20c. Location - City or Town, Stete Burlal 2 Cramation 3 Ramovel from Stete 22. Name and Addrass of Fecility SONS ELLA NOCE+ BUTO 322 S-HiGH ST --Enter the distance, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. ntervel Batween **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical 5EPSIS **Examiner** Due to (or es e consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying Ceuse (Diseese or Injury that Initiated events resulting In deeth) Lest Due to (or es e consequenca of). Records, P.O. Box 68760, Due to (or es e consequence of) signed by the a 23b. Dld tobacco use contribute to the cause of death? Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown HEPATIC CIMINOSIS þ 24b. Ware eutopsy findings availeble prior to completion of causa of daeth? 24e. Wes en eutopsy performed? Completed CUAGULOPATIOT peen s certificata has b director, paga 2 s COPD [CHAMIC OBSTRUCTIVE PULMONARY DISUBSIC 2 DONO 1 Yas 1 ☐ Yas 2 ☐ No Division of Vital Physician: 25. Wes casa referred to medical Certification: To Be 26. Piece of Death (Check only one) Hospitel: Other: 4 Nursing Home 1 Yes No Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 8 ☐ Other (Specify) After this Director: Aftar this d in by the funaral 28c. Injury at Work? 27. Mennar of Deeth 28d. Dascribe how injury occurred or Attending 1 Natural 5 Pending Invastigation death. 1 Yes 2 No 2 Accident 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direc complately filled in by 4 ☐ Homicida Hospital edicai Certifying Phyelclan: To the best of my knowledga, daeth occurred at tha tima, data and plece, and due to the causa(s) end manner as stated.

2 Medical Examiner: On tha basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date and placa, end due to the causa(s) end mannar stetad. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signetura egd title of cartifier 29c. Licansa number D15135 January 11,1999 560) LUCH NOVEW BLVD. 30. Name end eddress of person who complated cause of daeth (Itam 23e) (Type, Print) PENEUDE 5 WIT MD GUUD SAMMITHM IN SI. BATIMINE, MD 21234 PENEROPE 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar 4 1999



	1	Certificate of Death Reg. No.  1. Decedent's Nama (First, Middle, Last)  2. Dete of Death 3. Time of De														
Physician /Medical Examiner		George Thomas Quinn										January 11 <sup>Dey</sup> 1999 <sup>Year</sup> 5:30				
		a Facility Nema (II 1615 Pot Sp			and number)				4	Luthe	rvill		Balt	Ò.		
uneral irector		Social Security No. 102–20–6490	)	6. Sex 1 □XM		a (In yrs. I. 70	ast birthday) Yrs.	If Under Months	1 Yaar Days	If Undar a	24 Hrs. Min.	8. Data of Bir (Month, De June 22,	th by, Year) 1928	9. Birthpie Counti Corona	nce (Stata or Foreign y) 1,New York	
fahow	1	Suai Residence of Oe. Stete Maryland	10b. County	more Co	•		Town or Lo								d. Inside City Limits	
23a or 28a int be noti	1	0e. Street end Nun	Road				10f. Zip	Code 1093	П				ed States of Americ			
"natural", or terms 23a or 28a-f show adical Examinar must be notified at letted by Funeral Director		1. Meritai Status 1  Naver Merric 3  Widowed	rried 1	as Decedent med Forcas? Yes 2 1 Yes, Give eer or Detas:	Wes Deced	cedent of Hispanic Origin? (Specify Yes pecify Cuban, Mexican, Puerto Rican, e 2 2 No Specify:			ecity Yes or No Rican, etc.)	14. Rad Bie Specif						
		15. Decedent's Education (Specify only highast grade completed)				Confli	16e. Dece	dent's Usue kind of wor DO NOT us	k done	durina most	of worki	ng	16b. Kind of B	Specify: White  Sb. Kind of Business/Industry		
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matic event,	3 1		mond H. Quinn							18. Mothe			Middle, Maiden Sumeme)			
27 la		19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, 1615 Pot Spring Road Lutherville, Maryland 21093											Code)			
		0a. Mathod of Disp 1 ☑ Buriai 2 ☐ 4 ☐ Donetion	Cremation 5 Other (5	Specify)		Arli	ece of Disponentery, creaning ton	metory or o	ther plea	etery	01	Date /19/99	20c. Location Arlingto			
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sician	1	23e. Pert1. Enter the shock, or hear	ne disaase, on tellure. Lis	or complication t only one cer	ns thet caused use on each li	the deeth	. Do not en	er the mod	e of dyin	ig, such es	cardiec (	or respiretory e	errest,		Approximete Intervel Between Onsat and Death	
edical miner	ı	mmediete Cause ( disease or condition esulting in deeth)	Fine! n	a. A	Renal	Cel	es e conse	CINO/	ma,	me	tas	tatic	to lun	9	3-4 years	
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the bur		ausa. Enter Unda Ceuse (Diseese or het initieted events asulting in death) L	injury	c		Due to (or	es e consec	quence of):								
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his certificate has been s al director, page 2 should To Be Completed	2	exeminer?	No	Hospit	1 LI Inpatie		ER/Outpetie			er: 4 🗆 Nu	rsing Ho	me 5 Hasi	one) idance 6 🗆 Ot	har (Specify	eeth? IYes 2□ No	
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State Registrar 31. Dete filed (Month, Day Year)

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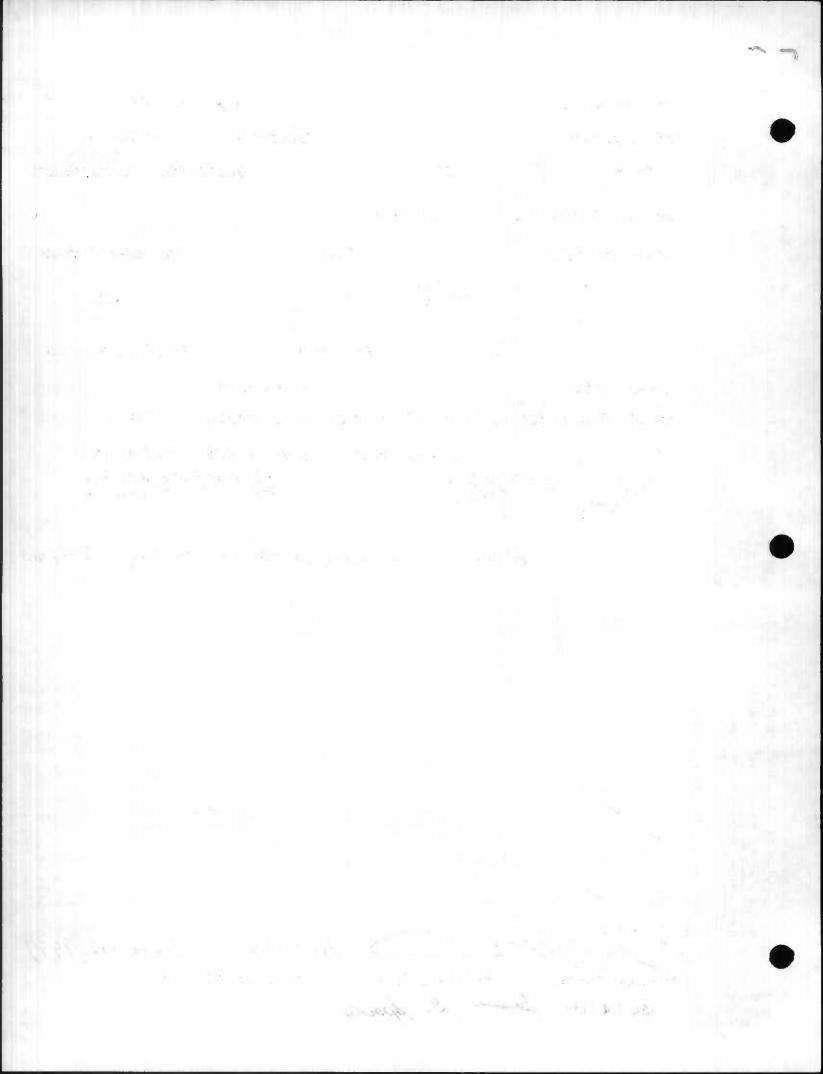
30. Name and address of person who completed cause of death (item 23e) (Type, Print)

Dr. Michael Carducci 600 North Wolfe Street 32. Registrar's Signature

January 12, 1999

21287

Baltimore, Maryland



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 18 per F.H G-767 1/22/99 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2:45 PM 11, 1999 BERTHA MARIE RAAB January /Medical 4a Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Lorien Nursing Home If Under 24 Hrs. Hours Min. If Under 1 Year 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F Months **Director** 214-26-7497 November 23,1916 Maryland Usual Residence of Decedent with the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28a-f ahow traumatic event, the Madical Examination must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21206 14 Chesley Avenue Funeral death 11 Marital Status 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian. Black, White, etc. filed within 72 hours efter 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Navar Married 2 □ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White p 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Eiamantary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 yr's 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be file finent of Health and Mental He lant: If Item 27 is marked oth fury or other traumatic even Be -Ihnor Buechler Mary B. ITTNER William 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5654 Whitby Road Baltimore, MD 21206 Patricia A. Hlavaty - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cramation 3 Ramoval from State permit. Page Department of Important: If any Injury or pace. 1/14/99 Timonium, MD Dulaney Valley 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Paul L. Hartsock, Jr. 22. Name and Address of Facility Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Rd. alsoch 23a. Part1. Enter the disaese, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Ceuse (Final diseasa or condition resulting in death) /Medical a CHROMIC PULMUMARY MUTAJE OBSTRUCTIVE Examiner Due to (or as a consequence of): Examiner certificeta be axacuted physician end s the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 80 USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? ed by th 1 Yes 2 No 3 Probably 4 Unknown HYPERTEMSION signed t Records, à 24b. Were eutopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy DIABETES MELLITUS certificata has 1 ☐ Yes 2 ☐ NO 1 ☐ Yes #☐ No CONCESTIVE HEART FAILURE Division of Vital 25. Was cese referred to medicel examinar? Be 28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 1 Yes 20 No this 28a. Dete of Injury (Month, Dey Year) funeral 27. Menner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending investigation or Attending after death. Director: Aft 1 | Yas 2 | No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) January 12, 1999 945 MY 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 21214 Parkway Balhmore MB 3007 Haris CMD Northern 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar 4 1999

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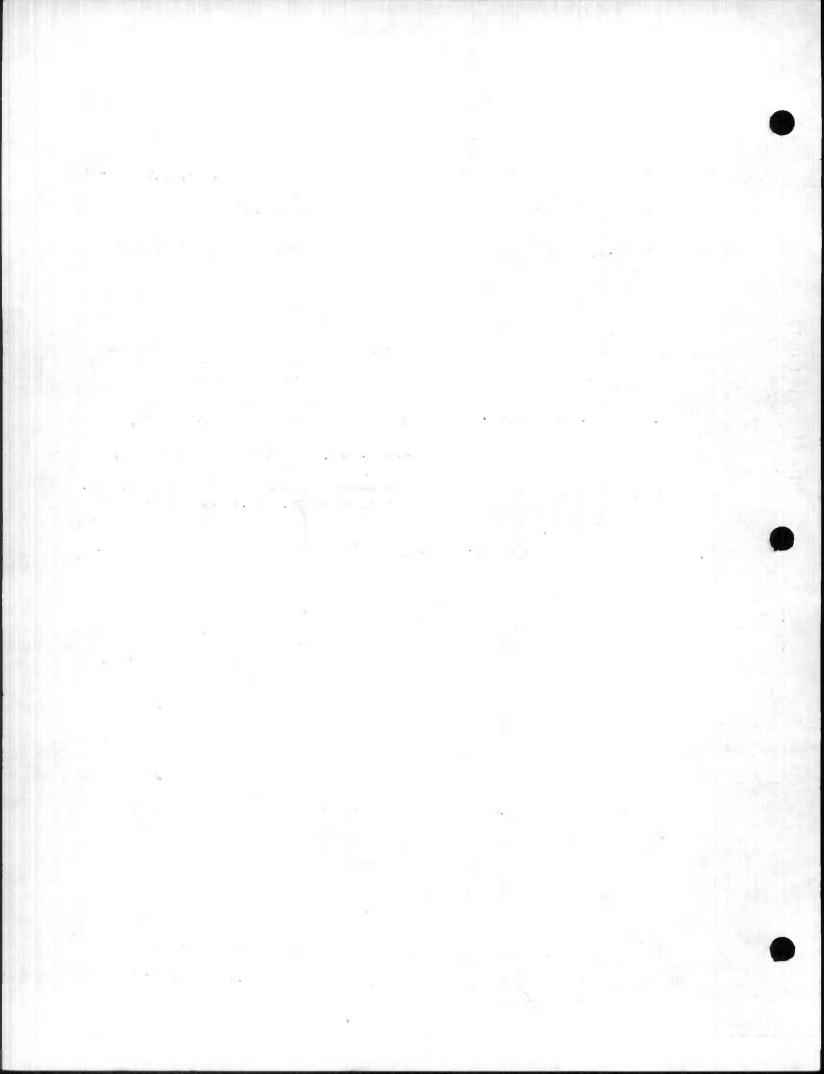
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 11:40 A.M. 1999 Real 10 Selma Mary January /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Hospital Center Baltimore tranklin Square Kosedale If Under 1 Yeer If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** 1 M 2 F Yrs. 52 212-46-9003 Director Dec. 29,1946 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Perry Hall Baltimore 1 Yes 2 No Maryland Director 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code United States 21128 4504 Silver Spring Road Funeral 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 20 Merried 1 ☐ Yes 2 ☒ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Own Home Homemaker 12 Years 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Be 2 should be to and Mental I Separtment of Health and Mental reportant: If Item 27 is marked or Frankie Nelson Barney Wolf 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stele, Zip Code) Mr. Wayne J. Real/Husband 4504 Silver Spring Road Perry Hall, MD 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c Location - City or Town State 20a. Method of Disposition Dete 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Elkridge, Maryland Meadowridge Mem. Park 1/14/99 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility Dive Duda-Ruck Funeral Home of Dundalk, Inc. dinine d. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1 Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock or heart feiture. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final End-Stage Pulmonary Fibrosis & Days disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es a consequence of): attending signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings aveilable prior to 24a. Wes en eutopsy peen Completed completion of ceusa of death? has 1 ☐ Yes 2 PNo 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: at or Attending P after death. After 1 Maturel 5 Pending investigetion 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral E Hospital edical 29e. Certifier Exertifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and menner steted. 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier January 10, 1999 0052628 MM 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Tarek Salkini, 9000 Franklin Square Drive, Baltimore, Maryland 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State Registrar

DHMH 16 Ray 6/95

REAL, Selma Mary

Box 68760. Records, P.O.

Division of Vital



Registrar

31. Data filed (Month, Day, Yaar)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Deeth 3. Time of Death 1 Decedent's Neme (First Middle Last) Month 1999 Ned 4b. City, Town, or Location of Death 4c. County of Death Stameu 4e Facility Name (If not institution, giva street and number) Johns Hopkins Bayview Medical Ctr. N/A Baltimore City If Under 1 Yaar If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplaca (State or Foraign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Months Deys 1€XM 2□ F Houra Vrs 238-22-1340 May 15, 1923 North Carolina Uaual Rasidence of Decedent 10a Stete 10h Counts 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Dundalk Baltimore 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 21222 1807 West Ave. United States 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yea, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indien. 11. Marital Status Bleck, White, atc. NYes 2 No If Yes, Give Yaar or Detes: 1 Never Merried 20X Married 1 ☐ Yes 2☐No Specify: 3 ☐ Widowed 4 ☐ Divorced WWII White 16e. Decedent's Usuel Occupation (Give kind of work dona during lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) during most of working Elementery/Secondery (0-12) College (1-4or 5+) Automobile Industry 9 Years Assembler 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) George Stamey Lara Baker 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent'a Name/Reletionship (Type, Print) Mrs. Jean Braun/Daughter in Law 100 Ann Ave. Essex, Maryland 21221 20b. Plece of Disposition (Name of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 N Burlel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) Lakeview Cemetery 1/13/1999 Randallstown, MD 21. Signature of Panaral Sarvice Licensaa 22. Nama end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. Red 7922 Wise Ave. Dundalk, Maryland 21222 23a. Pert1. Enter the diffease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart if the ship one cause on each line. Approximata Intervel Between Onsat and Death Immediate Cause (Final disaase or condition resulting in death) Kespira tory acrops Due to for and onchopleura Sequantielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence Dua to (or es e consequenca of): seudo monas 23b. Did tobacco use contribute to the cause of death? Pert II. Other algriftcant conditions contributing to death but not resulting in the underlying cause given In Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performad? 1 ☐ Yes 2 2 No 26. Pleca of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) Inpatient 2 ER/Outpetient 3 DOA 28b. Time of 28d. Describe how Injury occurred

**Examiner** Examiner certificate be executed ed by the attending physician and deteched for use as the buriel-trans Box 68760. Physician/Medical The law requires that the death signed by t Division of Vital Records, certificate hes been s irector, page 2 should Completed page Physician: Be 2 this Certification: s efter deeth.
I Director: After tid in by the funera To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by the

à

edical

State

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

r than "naturel", or items 23s or 28s-f show the Medical Exeminer must be notified at

other

permit. Pages 1 end 2 sh Department of Health and Important: If item 27 Is m eny Injury or other traum page.

**Physician** 

/Medical

2 should be f and Mental H Is marked Director

Funeral

à

Completed

2

with the Maryland

filed within 72 hours after death

Maryland 21215-0020

25. Wes case referred to medical examinar? 1 Yes 2 No 27. Menner of Deeth Dete of Injury (Month, Dey Yaer) 28c. Injury et Work? 5 Pending 1 ☐ Yes 2 ☐ No Investigetion 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide

29e. Certifier (Check only one) Certifying Physictan: To the best of my knowledge, deeth occurred et the time, dete and pleca, end due to the ceuse(a) and manner es stated.

2 Medicat Examtner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner stated.

end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

29c. Licanse number 29d. Data signed (Month, Dey, Year) KES-000 10

Philip Seo Johns Hopkins Bayview Med. Ctr. 4940 Eastern Ave. Baltimore,

31. Dete filed (Month, Day, Year)

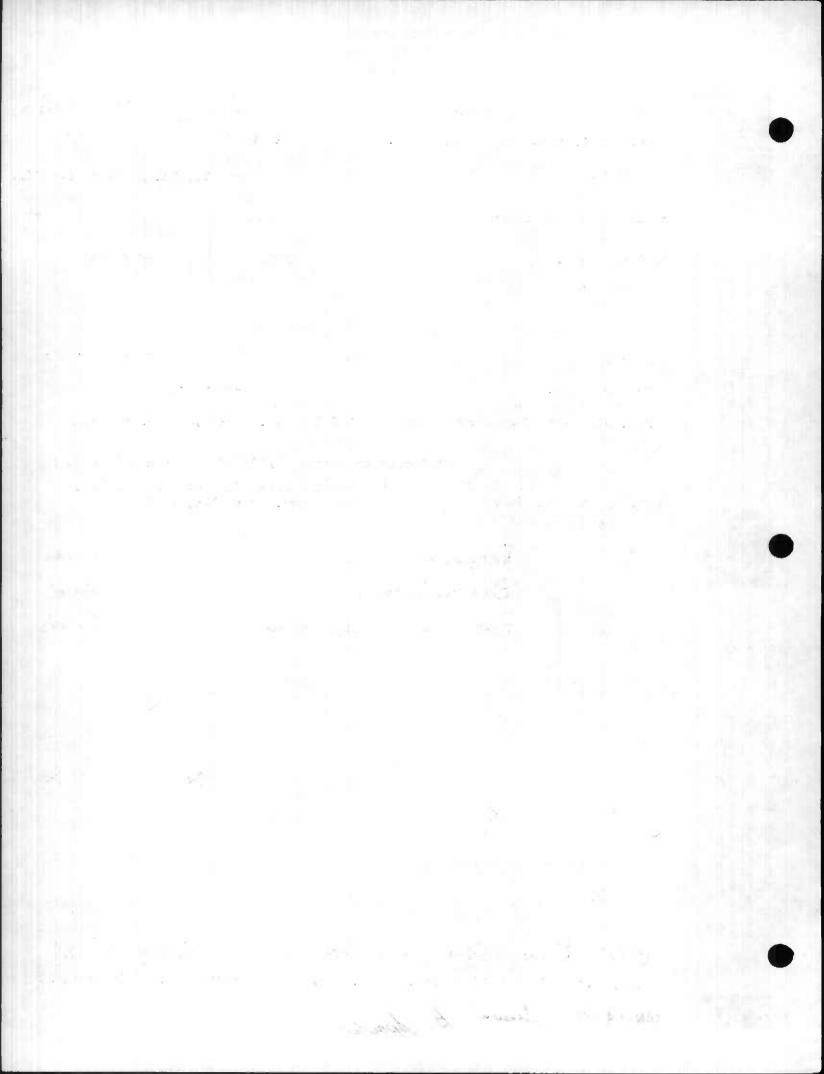
29b. Signature and title of certify

32. Registrer's Signeture

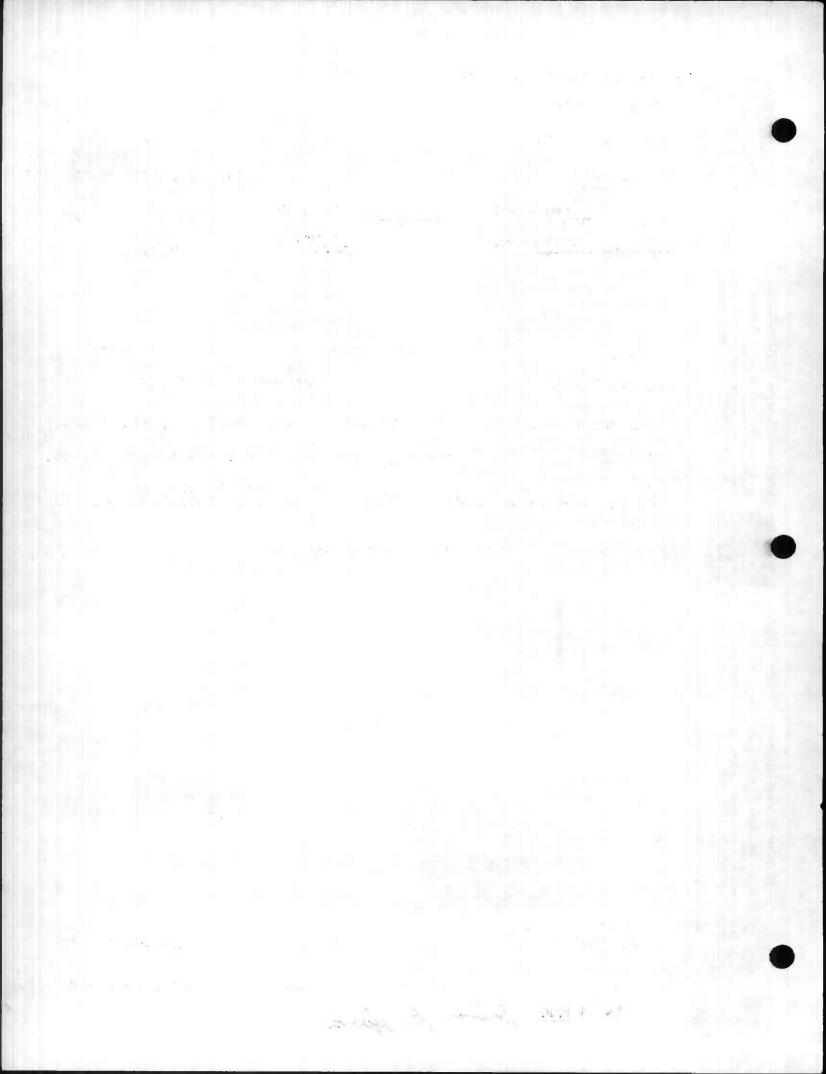
JAN 1 4 1999

Sports

Registrar **DHMH 16 Rev 6/95** 



	1. Decedent's Name (First, Middle, Last)  2. Date of Death										me of Death				
Physician Medical/		RETHA	SWAF								JAN. 10, 1999 7:54P				
Examiner	45 City Town or									4c. County	of Death ARUNDE	т.			
uneral	5.	Social Security Nur	-	6. Sex	7. Age	(In yrs. las	t birthday)	If Under 1 Year	If Under		Dete of Birth (Month, Dey,		9. Birthplace (S Country)		
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To Be Comp		Elementary/Second 3RD.	dary (0-12)	Co	ellege (1-4or 5-	+)		EWIFE	, u		194	OWN HOME			
event, Be C	17.	Father's Name (Fi										Maiden Sumem	e)		
										CE MACNEELEY					
5		e. Intormant's Nam											State, Zip Code)	_	
other t		NANCY QU a. Method of Dispos		/ DAUG	HTER	20b. Pled	e of Dispos	tion (Name of					2120 City or Town, St		
8		Burlal 2 Donation 5	Cremation  Other (Sp.	3 □Remov	al from State			CEMET		1/	13/99	BALTI	MORE,	MD.	
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edical miner	dis	mediate Cause (Fi sease or condition sulting in death)	nal	a			C BL	ADDER (	CANCE	R			UNI	KNOWI	
attending physician end for use as the burial-transit clan/Medical Examine	Ca tha rea	equentially list cond sny, leading to imm use. Enter Underly use (Disease or In it initiated events sulting in death) La	litlons, rediete ring jury st	c			s a consequ								
sicia	Pa	rt II. Other significa	ant conditio	ns contributi	ng to death bu	t not resulting	ng In the un	derlying ceuse g	iven in Part	i.	23b. Did to	obacco use cor	ntributa to the c	auss of dea	
tach tach											1□ Y	es XXIIo	3 Probably	4 Unkn	
28											24a. Was a perform	n autopsy med?	24b. Were au available completio of death?	prior to	
as been signed 2 should be de pieted by F											1□ Y	es 2 ANO	1 ☐ Yes	2 No	
page 2 shoul								0	thor		Check only or				
Be Be	25	. Was case reterred examiner?		Hospita	ıl: _	_			A N	ursing Home	5 Reside	ence 6 ∐Oth	er (Specify)		
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director, o Be	25	examiner?  1 Yes 2 No.  Manner of Death  1 Natural	5 ☐ Pending	gation not be	1 Li Inpatiei a. Date of Injur (Month, Day	Year) 28	Bb. Time of Injury	28c. Inju	ury at ork? ] Yes 2 []	No 280	d. Describe h	ow injury occurr	er or Rurel Rout	e Number,	
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s certific director	27	examiner?    Yes   X Ni   Manner of Death     Manuer of Death	5 Pending investig 6 Could redetermine	g pation and be ined 286	Date of Injur (Month, Day)  De Pleca of Injur building, etc.  To the best of the basis of the ba	ry - At home. (Specify)  If my knowle examination	Bb. Time of Injury  a, farm, stre	28c. Inju W M 1 [ et, factory, office  coccurred at the t stigation, in my 29c. Licen	ury at ork? Yes 2	No 286  286  and place, and the occurred	d. Describe had been described for Town described at the time, described for the catthe catthe catthe catthe catthe catthe catthe cattering for the ca	ow injury occur itreet end Numb n, Stete)  ause(s) and ma late and place,	er or Rurel Rout	ause(s)	
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director o Be	25 27 29 29 30.	examiner?  1   Yes   X   Ni  Manner of Death 1   Natural 2   Accident 3   Suicide 4   Homicide  a. Certifier (Check only one) b. Signature and lift  Name and addres  MICHAEL Date tiled (Month.)	5 Pending investig 6 Could n determine Medical is all committee soft person v	g Physician Examiner: O a	Date of Injur Date Date of Injur (Month, Day)  Pleca of Injur building, etc  To the best of not manner star  and cause of december  Date of Injur Date Date Date Date Date Date Date Date	y Year) 28  ry - At home (Specify)  f my knowle examination	Bb. Time of Injury  a, farm, streed odge, death and/or invented and/or invente	28c. Inju With Mind In Injury Mind Injury	ime, date ar opinion, des number 5 3 5 6 5	No 286 and place, and the occurred	d. Describe h.  Location (S City or Town  d due to the cat the time, d	treet end Numb n, Stete)  ause(s) and ma late and place,	er or Rurel Rout  anner as stated, and due to the c.	ause(s)	



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath Month DOMERS 1620 RIEDA JANUARY 10 4a, Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death MARYLAND MEDICAL SYSTEMS N/A OF BALTIMORE NIVERSITY If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foraign Country) 1□M 2X F Months Days 220-38-6935 57 March 3,1941 Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2406 Tionesta Rd. 21227 United States 12. Was Dacedant Ever in U,S. Armed Forcas? 14. Race - American Indian, Bleck, Whita, atc. Wes Dacedant of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 Navar Married 2 Married Yas 20 No f Yas, Giva Yeer or Detes: White 1 Yas 2 No Specify. 3 Widowed 4 N Divorced 15. Dacedant's Education (Spacify only highest grade completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Homemaker Domestic 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Behrens Mary Benny (Unknown) 19a. Informant's Nama/Ralationship (Typa, Print) 19b. Malling Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) David Somers / Son 63 Crain Ct. Apt. A3, Glen Burnie, MD 21061 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State Cedar Hill Cemetery 1/14/99 Baltimore, MD 4 Donation 5 Other (Spacify) 22. Nama and Address of Fecility CAFA Stephen D. Lohrman P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. dokun 8717 Green Pastures Dr., Baltimore, MD 21286 Approximata Interval Batween Onsat and Death Immediata Causa (Final disease or condition rasulting in death) ARDIOPULMONARY Dua to (or as a consequence of): SOFT CROTIZING Sequantially list conditions, if any, laading to immadiata ceusa. Enter Underlying Causa (Disaesa or Injury that Initiatad avants rasulting In daath) Last Dua to (or as e consequence of): Dua to (or as e consaquanca of): ULTIPLE RGAN Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No DIABETES. 24b. Wara autopsy findings eveilabla prior to complation of cause of death? 24a. Was an autopsy performed? PERIPHERAL DISEASE 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after death

Hygiane.

h and Mental H

Department of Health a Important: If Item 27 is any injury or other trau

Maryland 21215-0020

Baltimore,

the burial-transit

The law requires that the death certificate be executed igned by the attending p be datached for use as this certificata Hospital or Attending Physician: funeral director. After ours after death eral Director: A filled in by the f

Division of Vital Records, P.O. Box 68760,

Completed by Physician/Medical Be

Certification: To

25. Was cesa rafarrad to medicel axaminar? 27. Mannar of Death

Medicai

3 Suicida 4 Homicida 29a. Cartifian

1 Natural

2 Accident

1 ☐ Yas 2 No

6 Could not be dataminad

5 Panding invastigation

28a. Data of Injury (Month, Day Year)

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

Location (Straat and Number or Rural Routa Number, City or Town, Stata)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Dascribe how injury occurred

26. Placa of Death (Check only ona)

1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifia

29c. Licansa number 1007

29d. Date signed (Month, Day, Yeer)

who complated ceusa of death (Itam 23a) (Type, Print) 30. Nama/and addrass of person Ko

31. Data filad (Month, Day, Year)

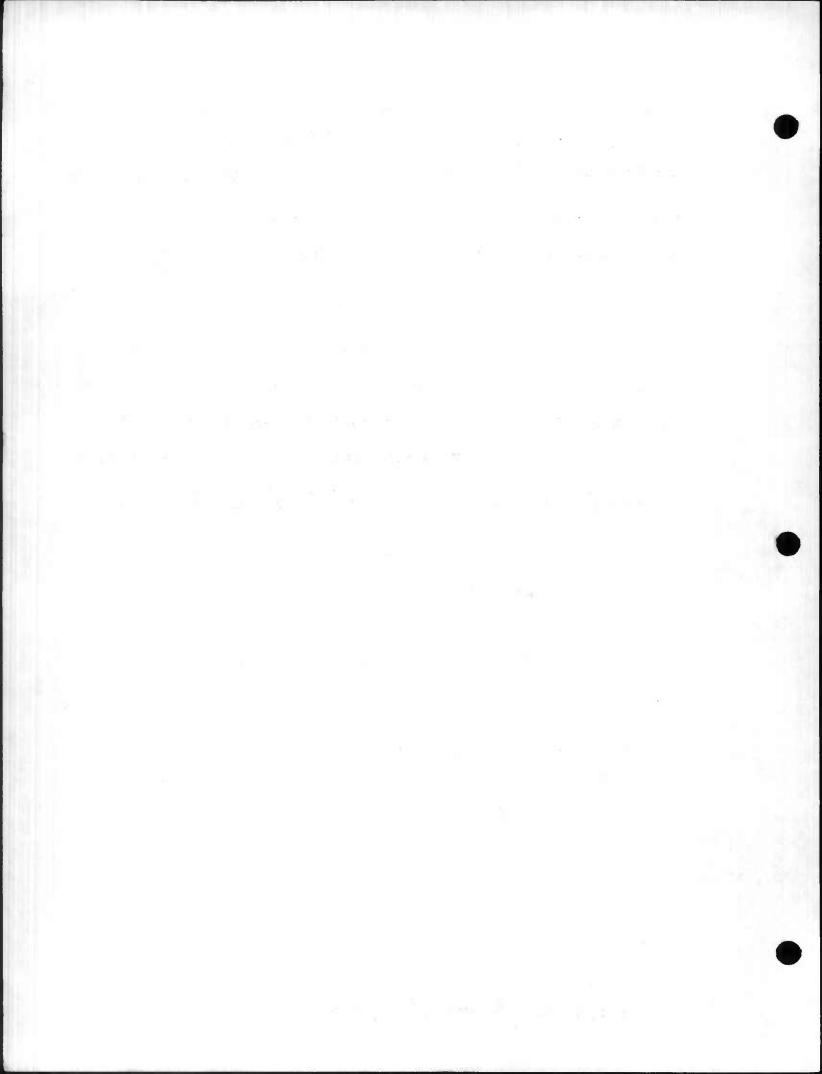
32. Pegistrar's Signatura

STREET BALTIMORE, MD 21201 GREENE

State Registrar

124 hours a

To the Within 2



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

WILLIAM	
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State of Maryland / Department of Health and Mental Hygiene 9 9

Physician
/Medical
Examiner

ITEMS: #23 PART i. II. 27. 28A-F PER MED 1. Decedent's Name (First, Middle, Last) William

4a Facility Name (If not institution, give street and number)

Sheppard

Certificate of Death

2. Dete of Death **JANUARY** 10,1999 3. Time of Death 2:14P.M.

**Funeral** 

4228 BIRCH AVE LOT #5 5. Social Security Number 1₩ 2□ F

**ABINGDON** If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday)

Months

4b. City, Town, or Location of Death 4c. County of Death HARFORD COUNTY

Director

280-1

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5

8

the Maryland

72 hours after

filed within 7 Hyglens.

parmit. Pages 1 and 2 should be fist.
Department of Health and Mental Hy Important: If Nam 27 is manked other any injury or other traumatic event.

**Physician** 

/Medical

Examiner

sician end buriel-transit

physician the burie

80 USB

page 2 a hes

this funeral

After

the

3

filled in

completely

death.

6

s efter death

24 hours Hospital

within 2 \$

The law requires that the death certificate be executed

Box 68760.

P.O.

Records.

of Vital Physician:

Division Attending

Baltimore, Maryland 21215-0020

Usual Residence of Decedent 10b. County Yrs

39

8. Date of Birth (Month, Day, Year) NOV • 22, 1959 Hours

 Birthplace (Steta or Foreign Country) New Jersey

(Unknown)

Directo

Funeral

à

Completed

Be

10a State Maryland

Harford

10c. City. Town or Location

Abingdon

10d Inside City Limits 1 Yes 2 No

10a Street and Number

4228 Birch Ave. Lot #5

10f Zin Code 21009

Days

10g. Citizen of What Country? United States

1 Never Married 2 Merried 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Race - American Indien, Black, White, etc. White Specify.

Construction

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

Welder

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Edward

11

James

Koleman

Sheppard

Tda

Mae

18. Mother's Name (First, Middle, Maiden Sumeme)

RIPW

Approximate Interval Between Onset end Death

19a. Informent's Name/Relationship (Type, Print)

Ida M. Sheppard / Mother 20a. Method of Disposition

19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 270 Sunshine Hollow Rd., McCullandtown, PA 15458

20b. Place of Disposition (Name of Dete Green Mount Crematory 1/15/99

20c. Location - City or Town, Stete Baltimore, MD

1 ☐ Burial 2 X Cremetion 3 ☐ Removel from Stete

4 □ Donation 5 □ Other (Specify) 21. Signature of Funaçal Service Lice

22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A.

8717 Green Pastures Dr., Baltimore, MD 21286

do 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line.

Examine

Physician/Medical

þ

Completed

Be

Certification: To

Immediate Cause (Finel disease or condition resulting in death)

NARCOTIC INTOXICATION

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or as a consequence of)

Due to (or es a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

ATHERSOCLEROTIC CARDIOVASCULAR DISEASE

24a. Wes an autopsy performed?

24b. Wera autopsy tindings available prior to completion of cause of death?

1 Yes 2 No 26. Place of Deeth (Check only one)

LETYas 2□ No

25. Was case referred to medical axaminer? TVYes 2 No 27. Manner of Death

1 Neturet

2 Accident

3 ☐ Suicide

4 | Homicide

5 Pending investigation 6 X Could not be

Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) Found: 1-10-99 28b. Time of Injury Found: 1:00 28e. Place of Injury - At homa, tarm, street, tactory, office building, atc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? P 1 Yes 2 No M

28d. Describe how injury occurred UNKNOWN

FOUND AT HOME 29e. Certifie (Check only one)

ABINGDON, MD. 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certified

29c. License number

29d. Date signed (Month, Day, Year)

4228 BIRCH AVE .

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

O.C.M.E.

JANUARY 11,1999

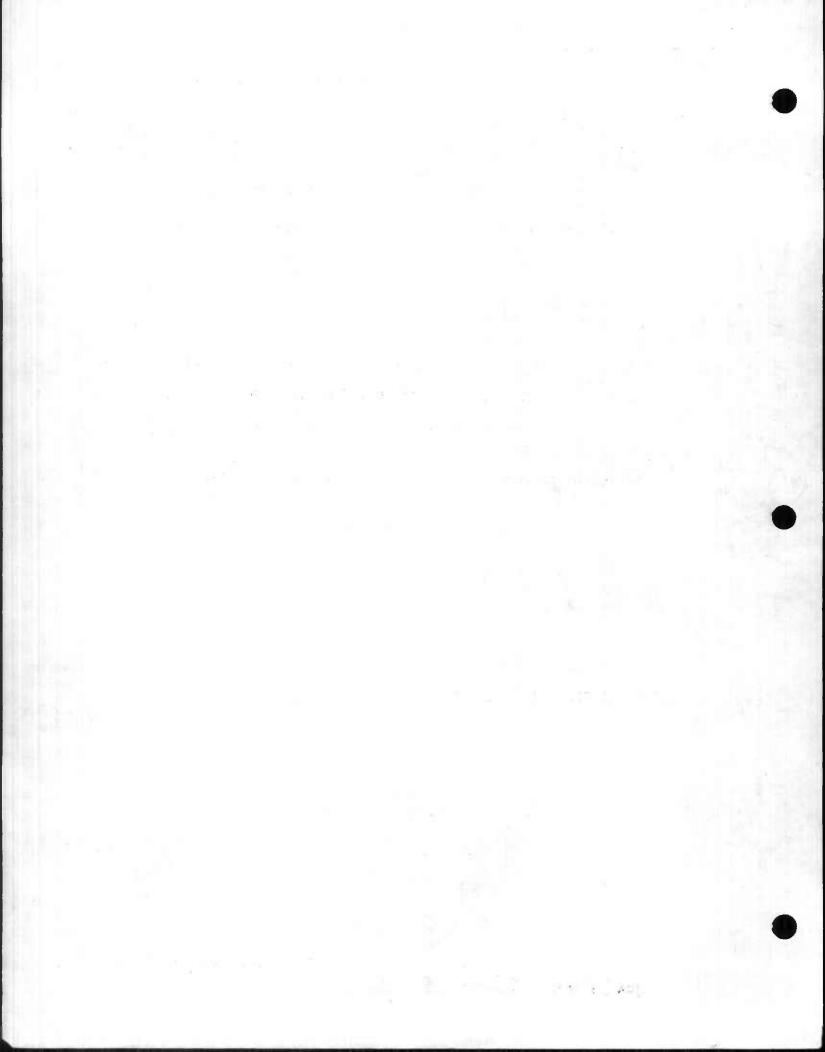
28t. Location (Street and Number or Rural Route Number, City or Town, Stata) 1222 DIDCU AUE

Stephen

Radentz MP 82. Registrer's Signature

111 Penn Street, Baltimore, Maryland 21201

State Registrar



				State of M	20A-F	Ce	lilloati	GUII	Dealii					2 7	of Death
Physic	an		me (First, Middle, L								2. Date of De Month	Day	Year		
/Medi			t Allen T	-					th Oh T-		JAN.	09, 199			55 AM
Exami	ner			ive street and number				_   '	BALT		ocation of Deat		/ A		
		5. Social Security			ge (In yrs. last b	irthday)	If Under	1 Year	If Under					olace (Stat	te or Foreign
Funeral Director		217-88- Usual Residence	-1086	17 M 20 F	29	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Di AUG 4			intry) /land	te or Foreign
Day Bu		10a. State	10b. County		10c. City, To	wn or L	ocation							10d. Inside	City Limits
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r 28s	Directo	10a. Street and N	lumber				10f. Zip	Code			10g. Citizen of What			intry?	
23a o unit.bs	777711	1529 Ra	amsay Str	eet			2	21223	3		USA				
8 85	Funeral	11. Maritel Stetus		12. Was Deceden Armed Forces		13.	Was Deced	Sent of H	lispanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	14. Rac		ican Indian,	
72 hours atter natural, or its fical Examin	1 2 7 1 1 1	MY OF The APPAIR COLORS							1, 1 00110	rto Rican, etc.)  Black, White, etc.  Specify: Whi					
Frank,	t, the Medical Exac Completed by	3 Widowed	4 Divorced	Year or Dates					орошу.						
		15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most life. DO NOT use retired)							t of work	ing	16b. Kind of B	usiness/li	ndustry		
within pro. than		Elementary/Secondary (0-12) College (1-4or 5+)  8  Warehouse Man													
H Bag									er's Name	Furniture 's Name (First, Middle, Maiden Sumame)					
fernal feed o	o Be		Taylor					4			esa D. Williams				
M M M	-		Name/Relationship	(Type, Print)	19	b. Meiti	na Address	(Street				er, City or Town	State, Z	io Code)	
and 2 n 27 is			Baker – A												
Head office of the		20a. Method of Di		DITC	20b, Place	of Dispo	osition (Nan	ne of		'	ltimore Date	20c. Location	21223 City or 1		
10 mm		1 Burial	2 ☐ Cremetion 3 5 ☐ Other (Spec	Removal from State	9		matory or o			0	1/ <sub>15/99</sub>	Baltin	nore	Md	
artin portan			Auneral Service Lio	-	Loudo		2. Name an				. 53	Datoi	11010	TIG.	
SQ THE		1	Lamir	1	0 100	Ga	ary L.	Kau	ıfman	Fun		me @ Mead		-	
_		23a. Pert1. Enter	disease, or co	mplications that cause y one cause on each	ed the death. Do	not en	25U_Wa ter the mod	shir e of dvin	ngton og. such as	B1V	d., Elk	ridge, I	Md.	21075 Approxin	nate
Physician		shock, or he	ear failure. List on	y one cause on each	line.			,						Interval E	Between nd Death
/Medical		Immediete Caus						Y					į		
Examiner		disease or condit resulting in death	tion i)	a. NARCOT	Due to (or as a			Int	oxicat	lon			1	-	
	Je.				Due to (or as a	CONSE	querica (ii)						1		
betu:	Examiner	Sequentially list of	conditions	b	Due to (or as a	conse	quence of):								
be executed ician and burial-transit	EX	if any, leading to cause. Enter Uni	immediale												
D 2 D	Cal	Cause (Disease of that initiated ever	nts	C	Due to (or as a consequence of):										
certificate Iding phys	Medica	resulting in death	) Last										1		
attendin for use	d  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											110000			
death he atter	Sici	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.							l.	23b. Did	tobacco use co	ontribute	to the caus	se of geath?	
that the de ed by the detached										1 Yes 2 No 3 Probably 4			Unknow		
8 5 2	d by										24a, Was	an autopsy	24b. V	Vere autop	sy findings
- A 60	ete											ormed?	8	vailable pri ompletion i	or to
has 20 2	Completed										. 500	/		death?	
- 40	ပိ	OF Was some	arrad to madiant									Yes 2 □ No	1	Yes 2	2□ No
9 2 5	m	25. Was case refearaminer?	en su to medical	Hospital:				Oth		or Deal	th (Check only	one)			
ysician: is certific director,	0	YYes 2[	□No	1 Inpai	ient 2KKR/C	)utpatie	nt 3 DC	A Out	4 N	irsina Ha	ome 5 Resi	idence 6 Otl	ner (Sner	ity)	

To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directors. Division of Medical Certification:

XYes 2□ No 27. Menner of Deeth

4 Homicide

29a. Certifier

1 Natural 5 Pending investigation 2 Accident 3 Suicide

6 X Could not be determined

28a. Date of Injury (Month, Day Year) UNKNOWN 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

UNKNOWN

28c. tnjury at Work? 1 Yes 2 No 28d. Describe how injury occurred UNKNOWN

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1529 RAMSEY ST. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

MM Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of ceptitie

FOUND AT HOME

29c. License number O.C.M.E 29d. Date signed (Month, Day, Year) JAN. 10, 1999

30. Name and addless pleted cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Pay, Year)

JAN 1 4 111 Penn Street, Baltimore, Maryland 21201

State Registrar

1999

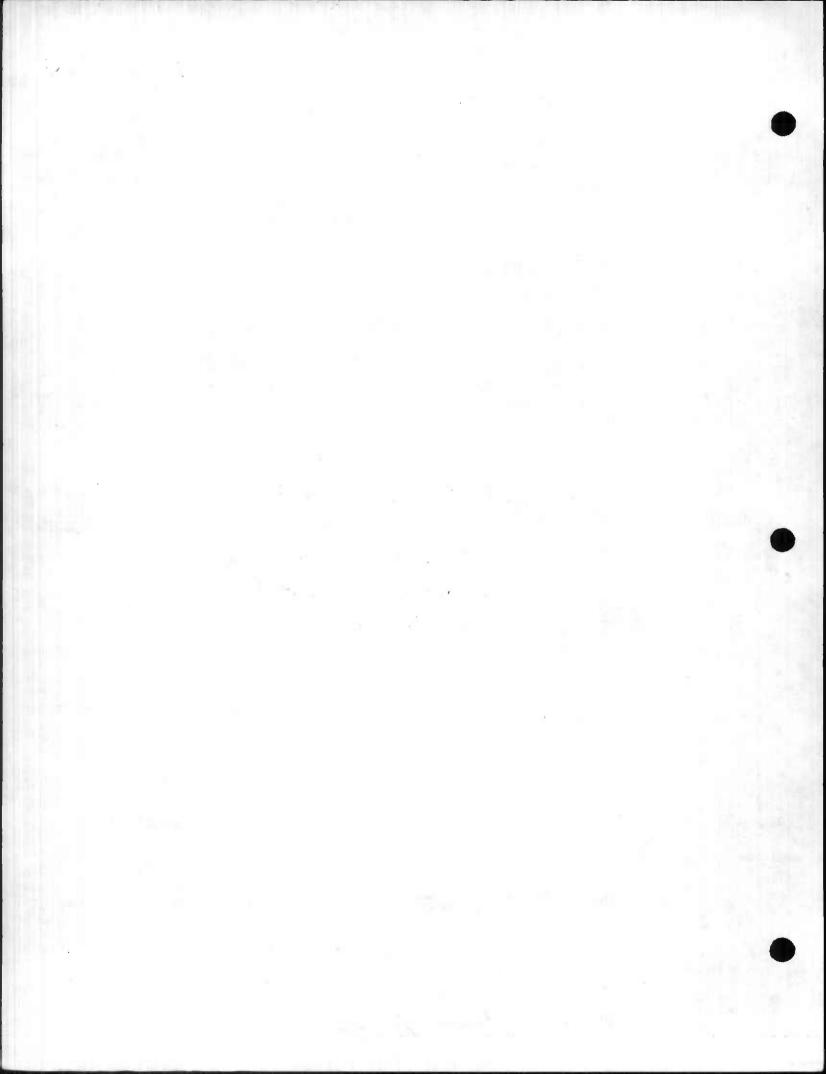
32. Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

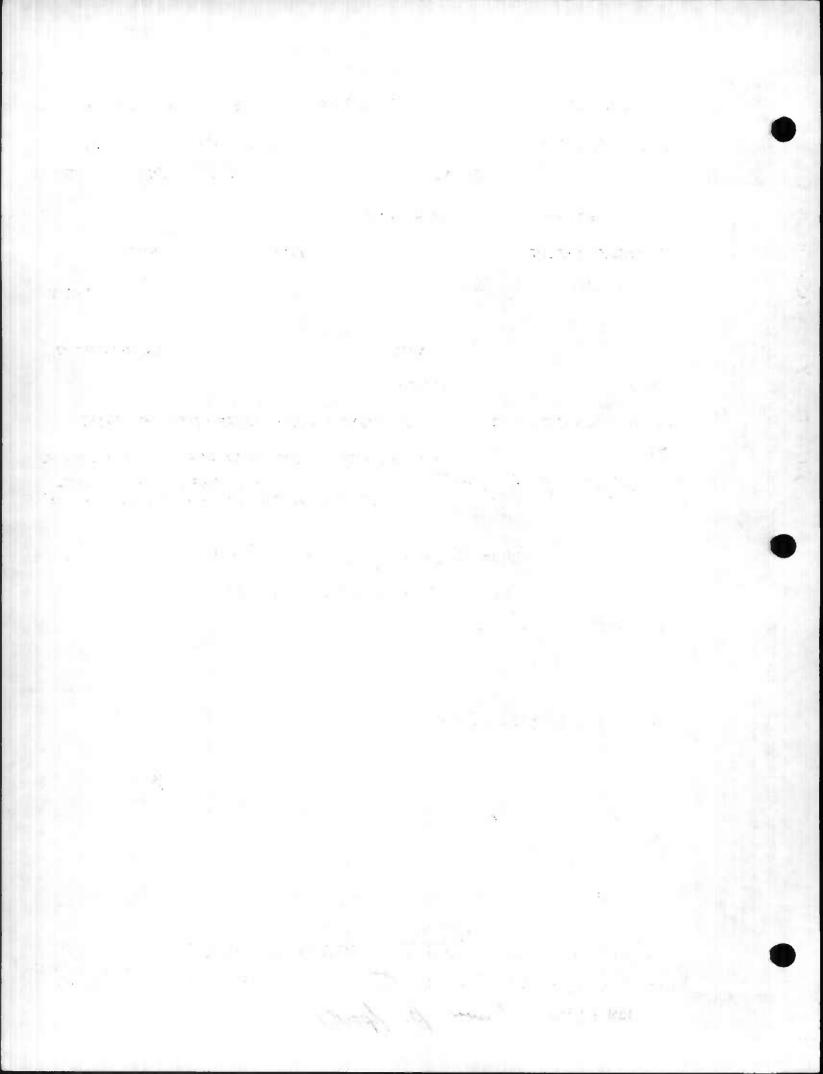
State of Maryland / Department of Health and Mental Hygiene 99 00574

				Certific	ate of Death	Re	g. No.		
	4.	1. Decedent's Name (First, Middle, La	st)			2. Date of Death		3. Time of Death	
	Physician /Medical	E 1 1	nk Van Brui	nt		JAN. 1	1, 1999	2:15pm	
	Examiner	4a Facility Name (If not institution, gh			4b. City, Town, o	Location of Death	4c. County of Death		
		Anne Arundel	Medical Cent		Annap		Anne A	Arunde1	
L	Funeral Director	5. Social Security Number 350-12-1145	Sex 7. Age (In yrs. 7)	Mont	der 1 Year   If Under 24 Hi hs Days   Hours   Mi	n. (Month, Day,		place (State or Foreign ntry) achusetts	
	D	Usual Residence of Decedent  10a. State 10b. County	10c C	ty. Town or Location			T	10d. Inside City Limits	
	ter deeth with the Marylan thems 23a or 28e-f show the maint be notified at a language.	, , , , , , , , , , , , , , , , , , , ,			Annapolis	140	g. Citizen of What Cou	1□ Yes 2□ No	
	A PO TO		o o d	101.	21401	10		intry	
	r flore 23 interment	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. Was De	cedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or No-	USA 14. Race - Ameri		
21215-0020	or Mr. or	3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☑ Yes 2 ☐ No If Yes, Give WW Year or Dates:	20 -101-0	specify Cuban, Mexican, Puess 2XI No Specify:	rto Rican, etc.)	Black, White,	nite	
2	2 2 3 3	15. Decedent's E	ducation ade completed)	16a. Decedent's U	Isual Occupation work done during most of w	ndkina 10	6b. Kind of Business/In	dustry	
121	within then then then then then then then the	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	T use retired)	U.S. Federal			
	The part of		5+	Economi		eme (First, Middle, M.	Governmen	ıt	
2	2 2 2 2					red Rae	aloen Surname)		
2	and Men and Men and Men	19a. Informant's Name/Relationship (		19h Mailing Addr	ress (Street and Number or I		City or Town State 7i	n Code)	
Σ Σ	of Land	Nelson Thomas							
6	T E E	20a. Method of Disposition	20b.	Name of or other place)		Oc. Location - City or To			
Ë	Pages mt: # it iry or o	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	IRemoval from State	tro Cremat		1/13/99	Baltimor	ce, MD	
	permit. Pag Department Important: if any injury o	21. Signature of Funeral Service Lice			and Address of Facility				
in a	2253	Dawn F.	McDonald McDonald	299	Frederick	Road Ba	ltimore,	MD 21228	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not enter the n	node of dying, such as cardi	ac or respiratory arres	st,	Approximete Interval Between Onset and Death	
	hysician /Medical	Immediate Cause (Final	· N			·	-	Crisei and Dealii	
	Examiner	disease or condition resulting in death)		mlugo		mest		5 ms	
				or as a consequence	01):				
	n and self-transit	Sequentially list conditions	0.	or es e consequence	of:	Diac	10	shaver > 14	
ó	Ex		the sale	4 2	och com	off .	cho a	reder 1 14	
68/60,	ing physician and a sa the buriel-transit	that initiated events resulting in death) Last	C. Due to (c	or es a consequence	of):			3	
ŏ ×	5								
	deam or deam o		0.						
	d by the attend etached for us	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlyin	g cause given in Part I.	23b. Did tob	secco use contribute t	to the cause of death?	
7	ed by the detached	Not	JE			1 ☐ Yes	\$ 2□ No 3□ Pro	bably 4 Unknown	
GS.	2 2 2					24a. Wes an	autoney 24b W	Vere autopsy findings	
Hecords,	_ M = _					perform	ed?	vailable prior to ompletion of cause	
ě	has 2 ag							death?	
= 1	certificate h rector, page					1 Ves	-	☐ Yes 2√ No	
VItal			Hospital:	I EDIO A STATE OF	Other	eeth (Check only one		26.4	
	areld T. T.		1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Year)	ER/Outpatient 302 28b. Time of	28c. Injury at Work?	28d. Describe how	nce 6 Other (Speci w injury occurred	(עי	
5	r death. eather: After by he funer	1 Natural 5 Pending 2 Accident investigation		100					
5	b 를 등 드	3 Suicide 6 Could not b	28e. Place of Injury - At h building, etc. (Speci	ome, ferm, street, fec fy)	tory, office	28f. Location (Stre City or Town,	on (Street and Number or Rural Route Number, Town, State)		
	24 hour Funer list ill dical		ysician: To the best of my knoniner: On the basis of examinating and manner stated.	owledge, death occurration end/or investigat	ed et the time, date and plaction, in my opinion, deeth occ	ce, and due to the car curred at the time, dat	use(s) and manner as the and place, and due to	stated. to the cause(s)	
4	Within Comple		1		29c. License number	29	d. Dete signed (Month,	Day, Year)	
	> - 0	Son	meh	_	H00528	43	1-11-	59	
		30. Name and address of person who	completed cause of death filter	The state of the s	Peter Sw		, .	1	
		180 Adn	well (-	char	e Driv	e an	rapolis	(M)	
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature		*			
		A Date of the contract of the		And the same of th					

ORIGINAL



				Cer	tificate o	of Death		F	leg. No.			
Physician (Madical	Decedent's Nama (First, Middla,     ANATOLIY	Last)		V	ASHCHE	IKO		2. Date of Dea Month	Day	Yaar QQQ	3. Tima of Deat	
/Medical Examiner	4a Eacility Name (If not institution,		nber)			Balti	own, or Loc	cation of Death	4c. County	of Death	1/A	
Funeral Director	5. Social Security Number 216–45–2955		7. Aga <i>(In yrs. i</i> 81	lest birthday) Yrs.	If Under 1 Ya	aar If Under		8. Date of Birth (Month, De) JAN . 1	(, Year)		place (State or Forestry)  RUSSIA	
Maryland -1 show	Usual Rasidence of Decedent  10a. State 10b. County  MD BALTI	MORE		y, Town or Lo						1	0d. Inside City Lin	
with the Ma	10e. Street and Number  9 DEERLODGE CO	URT			10f. Zip Coo	2111	7	,	10g. Citizen of W		ntry?	
of ZIZIS-UOZO filed within 72 hours efter death with the Maryland hypiene. ther than "naturel", or items 23s or 25s-f ehow ent, the Medical Examination of the completed by Funeral Director	11. Marital Status  1 Never Married **Married  3 Widowed 4 Divorced	12. Wes Dace Armed Fo	2 No	81	Vas Decedent Ves, specity (	of Hispanic Or Cuban, Mexica	rigin? (Spe n, Puerto I	cify Yas or No- Rican, atc.)		e - Amario k, White,	ean indian, etc. WHITE	
ind XIXIS-UUXU be filled within 72 hours of tal hygiene. d other than "naturel", or event, the Medical Estim Be Completed by I	15. Decedent's (Specify only highast Elementery/Secondary (0-12)	Education greda completed) College (1	-4or 5+)	(Give	lent's Usuai Oo kind of work do OO NOT use re	ne during mos	st of workin	ng	16b. Kind of Bu		dustry	
E SES W	17. Father's Name (First, Middle, La	est)	VA	SHCHEN	КО	18. Moth	er's Name MAR		Meiden Sumem KOUFM			
M day	19e. Informant's Name/Relationship VALERYA VASHCHE			9 DEE	RLODGE	COURT		INGS MI	r, City or Town, LLS, MD	211	17	
5 8 5 2 2	20e. Method of Disposition  CXBurial 2 Cramation 3  4 Donation 5 Other (Spe	cify)	State	emetery, cren LTIMOR		plece) EW CEME		1/12/9	20c. Location -		ORE, MD	
permit. Pag Department important: h any injury o	21. Signature of Eneral Service Lie	CO	5		Nama and A		SOL		SON & BE		INC. MD 2120	)8
Physician /Medical Examiner page 184 Examiner Fall Examiner	23a. Part1. Enter the disease, or or shock, or heart failure. List or immediate Ceuse (Final disaasa or condition resulting in death)  Sequentially list conditions, if any, leeding to immediate	e. Adul-	Due to (o		y Dis juence of): Syske						Interval Between Onset and Deeth	1
entificeta be sing physicia se as the bu	Sequentially list conditions, if any, leeding to Immediate cause. Enter Undertying Cause (Disease or Injury that initiated events rasulting in death) Last	s. Sept	Due to (or	r as a conseq	uence of):							
tha cythe checked	Part II. Other significant conditions  Duodenal p		nderlying caus	e given in Part	i.	23b. Did tobacco use contribut		3 Pro				
require should should eted									en autopsy med?	av	ere autopsy findin vailable prior to empletion of cause death?	
cian: centific ector,	25. Was case referred to medical examiner?	Hospitel:	npatient 2			Other:		1 Check only o	ne)		Yes 2 No	
ng Phys fter this uneral di	1 Yes 2 No  27. Mannar of Death  1 Netural 5 Pending investiga	28b. Time of injury					lence 6 LIOth now Injury occuri		(fy)			
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funera Medical Certification:								28f. Location (S City or Tox	Street end Numb vn, Steta)	er or Rur	al Routa Number,	
To the Hospital or within 24 hours afte to the Funeral Dir completely filled in Medical Cert	29e. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, dete and service one)  Certifying Physician: To the best of my knowledge, death occurred at the time, dete and service one)  Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deat and manner stated.								th occurred at the time, date end plece, and due to the cause(s)			
Tot with Tot com	29b. Signeture and fittle of certifier  Goch Er  30. Neme and address of person with	no completed caus	0. 1	1	AS Print)	2402		9493 -	29d. Date signer	10, Baltin	1999 more, Maryl	snd
State Registrar	31. Date filed (Month, Dey, Year)  "JAN 1 4 199		SOQI t egistrar's Signa	tospitaliure	Spark		Belve	overe A	ivenue,		21215	

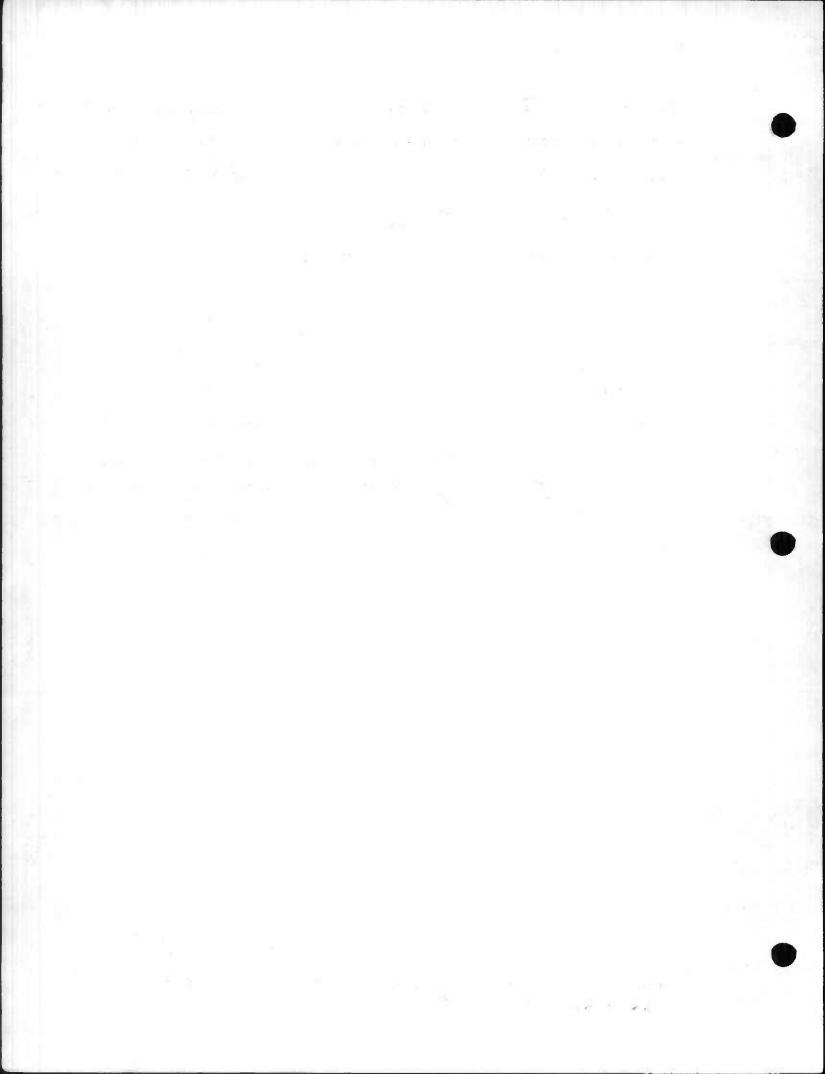


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Certificate of Death

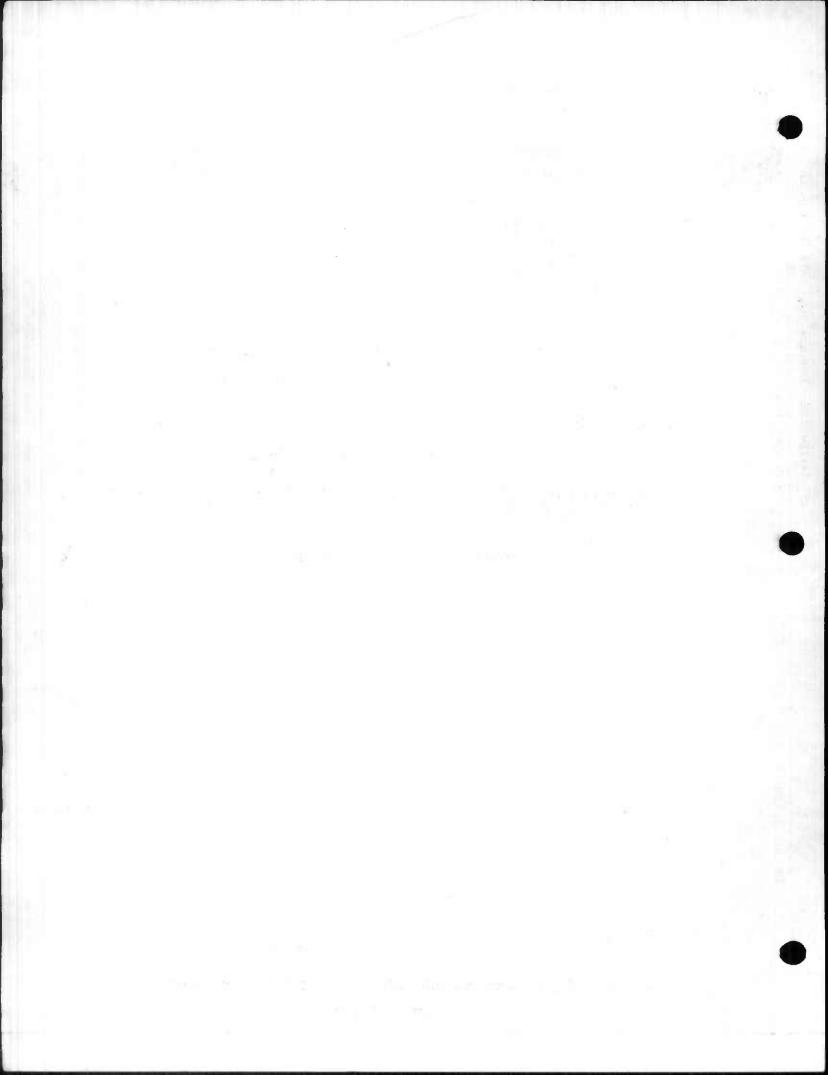
					Cei	rtificate	of i	Death		Re	g. No.			
Physici /Medic		1. Decedant's Nama (First, Middle, Las	St)		Wol	f				2. Data of Death Month J Chium		Yaar 99		of Death
Examin		4a. Facility Nama (If not institution, given Johns Hopkins Bay			14 Dep	icr timen	LI	30 1+1-	wn, or Lo ~つ/と	cation of Daat	4c. County	of Death		
Funeral Director		5. Social Sacurity Number 6. S		7. Aga (In yrs.			Yaar		24 Hrs.	8. Data of Birth (Month, Day,	de-	9. Birthp	iaca (State try) ylar	e o <i>r Foreig</i> n nd
r 28a-f show	tor	10a. Stata 10b. County  MD BaltImo	re	10c. Cit	ly, Town or Lo	ocation						1		City Limits
3a or 28	al Director	10e. Street and Number 956 Dalton Ave	nue			10f. Zip 0	Coda	2.4		10	g. Citizen of	What Cour	itry?	
na Process and coats with the maryand tall Hygiene (all Hygiene) of other than "natural", or flow a 23 or 28a-f show event, the Medical Examinal must be notified at	by Funeral	11. Maritai Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced		2X) No			nt of H	lispanic On an, Maxicar		cify Yas or No- Rican, atc.)	14. Rac	ce - Amaric ck, Whita,	atc.	
"natural",	Completed	15. Decedant'a Ed (Specify only highest gra	de completed)		16a. Daced (Give life, L	dent's Usuai kind of work DO NOT use	Occup done	ation during mos	t of worki	ng	8b. Kind of B			× =
Mental Hygiene. arked other than artic event, tre M	Com	Elamantary/Secondary (0-12) 7 17. Fathar's Nama (First, Middle, Last)	Collaga (1	-4or 5+)		lerk					SocIa		curI	ty
h and Mental Hygi	To Be	BlasIus Wolf								Dunne		10)		
and		19a. intormant's Neme/Ralationship (1	ype, Print)		19b. Meilir	ng Addrass (	Street	an <i>d Numb</i> e	er or Rura	Route Number,	City or Town	State, Zip	Code)	
ENL		John F. Wolf						Rd.	Bal	tlmore	, MD	2122	2	
50 2		20a. Mathod of Disposition  1 Buriai 2 Cramation 3 4 Donation 5 Other (Specify		Stata	Place of Dispo cematary, crem lt/Wa	natory or oth	er plac	*	y 1	Dete 2 2 - 10 - 9 9	oc. Location Lau:	city or To		
Department Important: 1 any Injury o		21. Signatural Funaral Sarvice Licen	Ob	· GIV	/ C.	Nama and harle	Addra	ss of Facilit S. Ze	eIle	r & So Balt	n Fun	eral	Hom 212	e, I
hysician /Medical ixaminer		23a. Part1. Enter tha disaasa, or come shock, or haart tailura. List only disaasa or condition rasulting in death)	a. C O	ach iina.					cardiac o	r raspiratory arra	st,		Approxim Interval B Onsat an	nata Between nd Death
a tis	niner		A o	rtic	Stero	Sisc							unka	مساها
physician and s the burial-transit	ai Examiner	Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or injury thet initiated evants	Pul	Dua to (o	or as a conseq	uance of):	rte	rion					unka	wwa
D a	Medicai	rasulting in death) Last		erten		uance of):						U	inkni	نب
attending d for use as	ician	Part II. Other significant conditions or		ath had not one	idain - In Ab	a dambi da a la		and Deal		BOL Dida-				
een signed by the attend	by Physician	Parti. Other significant conditions of	withouting to de	atti but not ras	uning in tha ui	ndariying cat	usa giv	en in Part I			s 2 No			Unknow
2 8	Completed to									24a. Was ar perform	autopsy ed?	av	era autops aliable prio mpletion o death?	or to
pag			•							1□ Ya	s 2000	10	Yas 2	No
this certificate	To Be	16 145 25410			€R/Outpatien			ar: 4□ Nu		(Check only one		ar (Specif	v)	
After fune	27. Mannar of Death 1 De Natural 2 Accidant invastigation 3 Suicida 4 Homicida 28a. Data of injury (Month, Day Year) 28b. Tima of Injury Work? 1 Year 28b. Tima of Injury M 1 Year 28c. injury at Work? 28c. injury at Work? 28c. injury at Work? 1 Year 28c. injury at Work? 1 Year 28c. injury at Work?					28d. Dascribe how injury occurred								
within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicida detarmined	28a. Place buildir	ig, atc. (Specif	y)					28f. Location (Str City or Town	State)			ımber,
• Fune	edicai	29a. Cartifiar (Check only one) 1. Certifying Phy 2 Medical Exam	rsician: To tha inar: On tha ba and mann	sis of axaminal	wledga, daath tion and/or inv	occurred at astigation, in	tha tim	na, data an pinion, daa	d piace, a th occurre	nd due to the ca ed at tha tima, da	usa(s) and ma ta and piace,	annar as si and dua to	ated. tha cause	a(s)
To the	M	29b. Signatura and titla of certifiar	h					a number	000	29 J	d. Data signe	d (Month.	Day, Year)	)
		30. Nama and address of person who of Brenda P. Snith		a ot deeth (Itam Johns gistrar's Signa		Print)	2		Em	J.m. rensency	Do pri	-tm	1.4.	and the second
I			2- 1	12625	1 th sole	- 5	20 V	UIV		EL DEVER	INCHE	1.	V 1 "	



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State of Maryland / Department of Health and Mental Hygiene

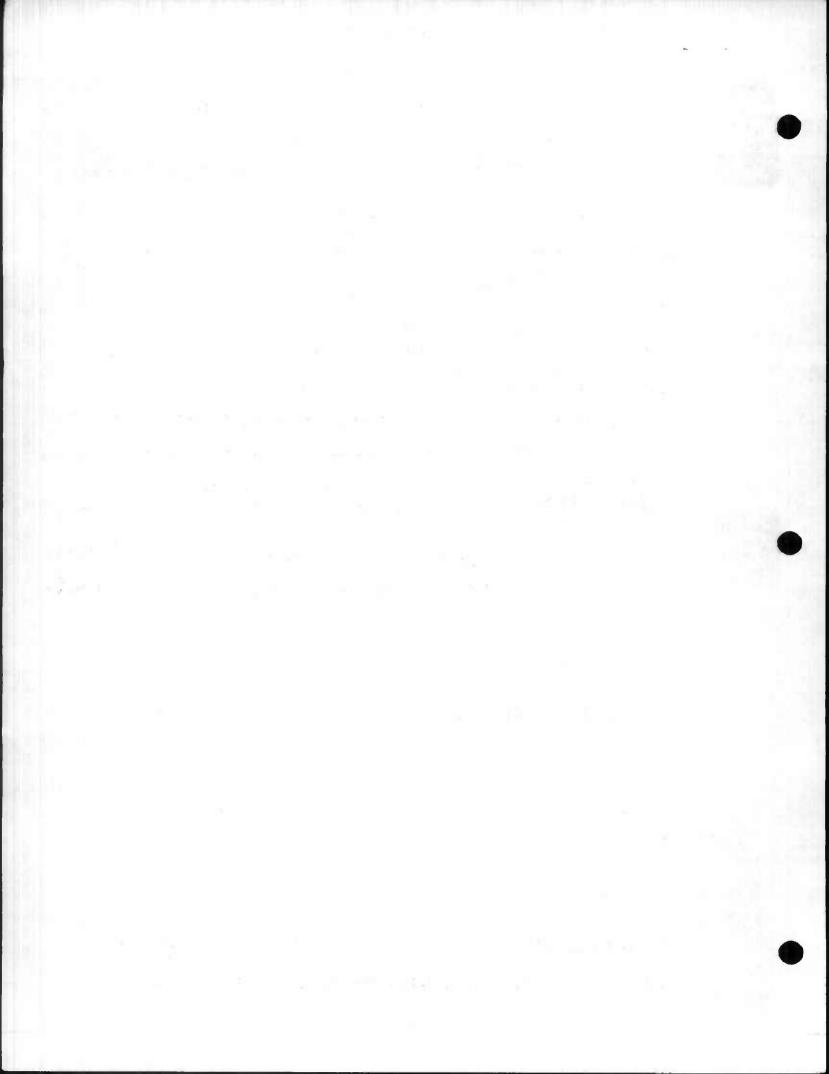
	1. Decedent	t's Neme (F	irst, Middle, I	Last)								2. Deta	f Deeth	g. No.		3. Ti	ma of Death
ician dical		Rol	bin J	. Ze	e							JAN		Pay 1	999	9:	25 PM
niner	4a. Facility ! Stel	la Ma	nt institution, g A L 1 S	give street	end number)	)				4b. City, To Town	own, or L	ocation of I	Deeth	4c. Coun Ba	ty of Deeti	nore	
al or		24-4	118	3. Sex		ge (In yrs. 71	lest birthday) Yrs.	Months	Days		24 Hrs. Min.	8. Dete d	Birth Bay	1927	9. Birth	hplace (S unin) 11na	itete or Foreign
	Usuei Resid		b. County			10c. Ci	ity, Town or Lo	ocation								10d. Insi	ida City Limits
oto	MD		Balt	imor	e		Glen	Arm								1□	Yes 2No
Funeral Director	10e. Street :		Manor	Roa	ıd			10f. Zi	Code 21	057			10	g. Citizen of US		untry?	
þ	3 □ Wid		Married	d 1	es Decedent med Forces? ☐ Yes 25☐ Yes, Give aar or Dates:	7		Was Dece If Yas, spe 1 Yes		Hispenic Or ean, Mexica Specify		ecify Yes of Rican, etc	r No- )	Bi	ace · Amer eck, White ify: Eur	e, etc.	
Completed	Elemente	15. (Specify only) ry/Seconde	Decedent's only highest g	grede com	opleted)	5+)	16e. Dece (Give life.							State			ent
To Be	17. Fethar's	Name (Firs	st, Middle, Las	est)						General Services State Government  18. Mother's Nama (First, Middle, Maiden Surneme)  Loretta Blanchfield							
	19e. Informent's Neme/Reletionship (Type, Print)  Jane K. Zee/Wife  19b. Meiling Address (Street end Number of 11600 Manor Road G.							er or Rui	ral Route N	um <i>ber</i> ,	City or Tow	n, Stete, Z	(ip Code)				
				9		201					Gler						
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State of Maryland /	Department	of Health	and	Mental	Hygiene	-
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Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth 1999 Yeer **Physician** January 1, 7:10 PM Spedden Louise Wright /Medical 4b. City, Town, or Location of Deeth 4a. Fecility Neme (If not Institution, give street and number) 4c. County of Deeth Examiner Talbot St. Michaels 204 Lincoln Avenue 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Sept 22, 1 7. Age (In yrs. last birthdey) Birthpiece (State or Foreign Country) **Funeral** 1 M 2 DYF Months Deys Hours Yrs. 1903 Maryland Director 218-34-8555 Usuel Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantmer must be not the page. 10e State 10b. County 10c City Town or Location 10d. Inside City Limits Yes 2□No Director Talbot St. Michaels Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21663 US 204 Lincoln Avenue Baltimore, Maryland 21215-0020  $\mathscr{H} lpha$ by Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 27 No 1 Yes, Give A Yeer or Detes: 11. Maritei Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3☐Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Rusiness/Industry Eiementery/Secondery (0-12) Coilege (1-4or 5+) 5+ 11 School Teacher Education 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Emma Doenges William Hamilton Spedden 2 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 204 Lincoln Avenue St. Michaels, Maryland 21663 John H.S. Wright 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Doneţion 5 ☐ Other (Specify) 1/5/99 Christ Churchyard Cambridge, Maryland 21. Signatura Funerel Service Licensee 22. Name end Address of Fecility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Per l. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory e should or heart feiture. List only one cause on each line. Approximete interval Between Onsef and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medicai Examiner physician and the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Division of Vital Records, P.O. Box 68760, requires that the death certificate be Due to (or es e consequence of) use as t Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS þ 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peen certificate has page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No director. 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospifel: 1 ☐ inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 After this 27. Manner of Deeth 28e. Dete of injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. injury et Work? Hospital or Attanding 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours edical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted. (Check only one) within 2 the 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 126350 30. Neme end eddress of person who completed cause of deeth (item 23e) (Type, Print) William S. Bremer, M.D. 800 S. Talbot Street St. Michaels, Maryland 21663 31. Defe filed (Month, Day, Year) 32. Registrer's Signeture State Registrar G. Sparker



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time the JUANITA PEARL BRADLEY 1628 01 02 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Cambridge Dorchester Dorchester General Hospital 7. Age (In yrs. lest birthday) If Under 1 Yeer if Undar 24 Hrs.

Q7 Months Deys Hours Min. 5. Social Security Number 8. Deta of Birth (Month, Day, Year) 9. Birthplece (Steta or Foreign Country) Oklahoma 10 M 25 212-18-6518 Yrs. Usuel Residance of Decedent 10e. Steta 10b. County 10c. City, Town or Location 10d. inside City Limits Dorchester Vienna MD 1 □ Yes 25 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21869 4511 Ocean Gateway U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indien, Bleck, Whita, atc. Wes Dacedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Naver Merried 2 Married 1 Yes 2 No If Yes, Give Year or Dates: white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) College (1-4or 5+) licensed practical nurse state hospital 17. Father's Name (First, Middla, Last) 18. Mother's Nema (First, Middle, Melden Sumame) Andrew Cloud. Pear1 19a. Informent's Neme/Raiationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 7663 Marcy Drive, Glen Burnie MD 21060 James E. Bradley - son 20b. Placa of Disposition (Neme of camatery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Ramoval from State Dorchester Memorial Park 1/6/99 Cambridge, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home 21. Signatura of Fugerel Sarvice Licansee 700 Locust St. Cambridge MD 21613 23e. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or haert failure. List only one cause on each line. Immediete Ceusa (Final diseese or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to Immedieta causa. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in deeth) Last Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown 24b. Were autopsy findings evalleble prior to completion of causa of deeth? Disease 24a. Was an autopsy performed? KINSONS 1 Yes 25No 1 ☐ Yes 2500 25. Was case refarred to medical exeminer? 26. Placa of Daath (Check only one) 1 Yes 2 No 1 Napatient 2 ER/Outpetient 3 DOA Othar: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mennar of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, straat, fectory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 4 Homlcide 29e. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the tima, data end pleca, end due to the causa(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and placa, and due to the cause(s) end manner stated.

Box 68760, P.O. Division of Vital Records,

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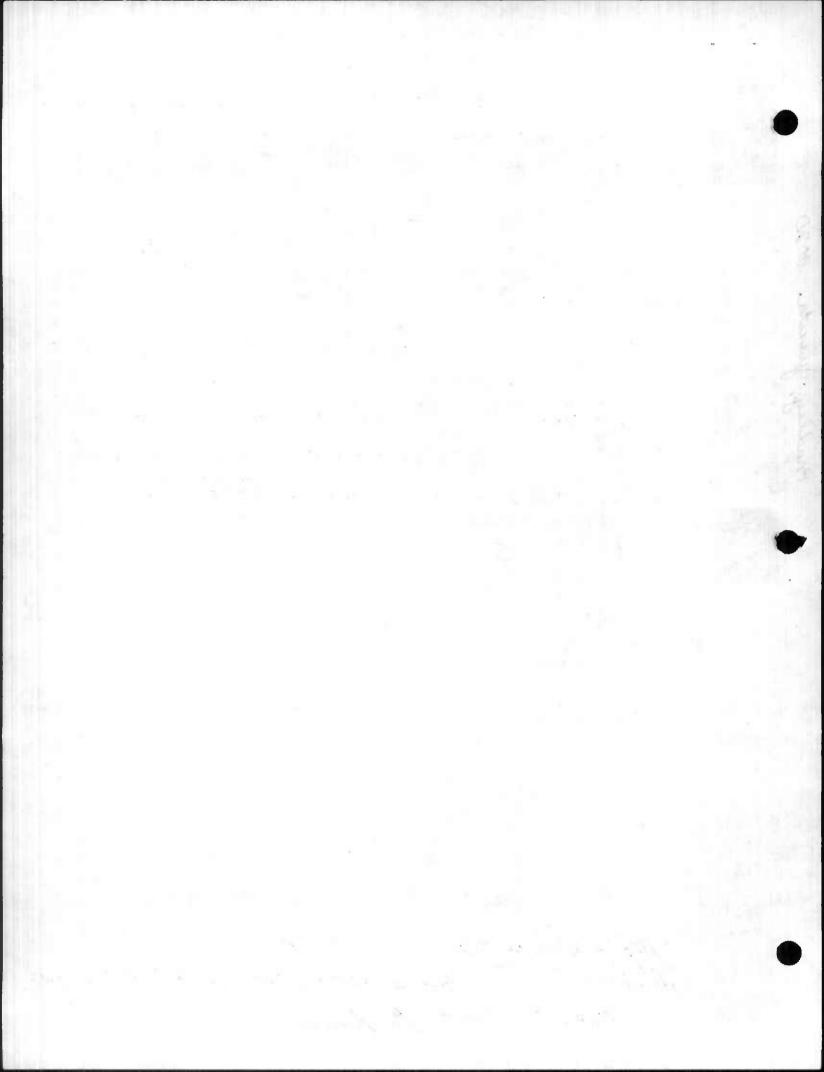
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302 Collins Ave Hurlock Md 2/643

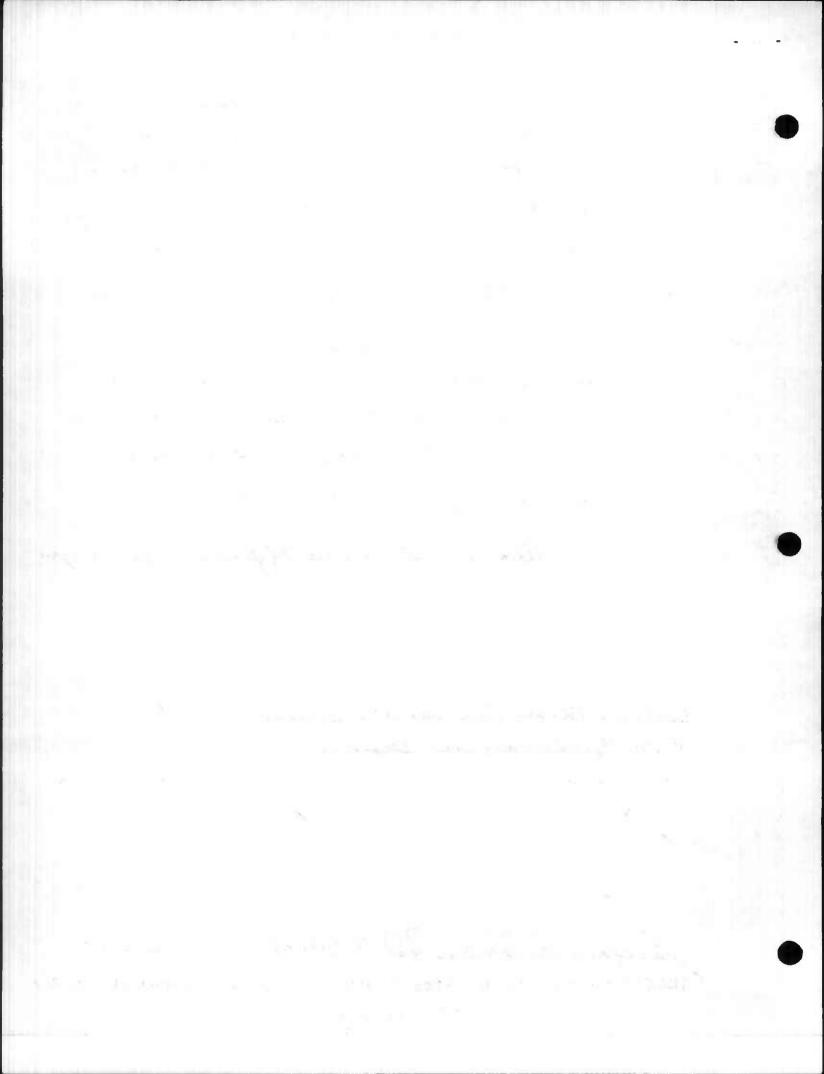
29d. Data signed (Month, Dey, Year)



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State of Maryland / Department of Health and Mental Hygiene

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-f show fled at	tor	Usuel Residence of Decedent  10e. Stete 10b. County Some	erset	10c. 0	City, Town or Lo	ocation Crist	field			10	0d. Inside City Limits
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** January 2, 1999 2200 Anna Marie Allen /Medicai 4a. Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 109 A Courtney Drive Elkton Cecil If Undar 1 Yaar | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Dey, Yaer) 5. Social Sacurity Number 7. Age (In vrs. lest birthday) 9. Birthplace (Stete or Foreign **Funeral** 1 □ M 2 및 F 59 Yrs. October 20, 1939 Maryland Director 213-36-9449 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Insida City Limits Funeral Director 1 Yas 2 No Maryland Cecil Elkton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 109 A Courtney Drive 21921 United States 12. Was Decadent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after Yes 2 No 0. 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☑ No Specify: by 3 Widowed 4X Divorced Yaar or Dates: Completed the Medical 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 127 is marked other than "n r traumatic event Cecil County Board Elementary/Secondary (0-12) College (1-4or 5+) 12 Bus Driver of Education 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be permit. Pages 1 end 2 should be t Department of Health and Mental I Important: if Item 27 is marked of any Injury or other traumatic eve Catherine Anna Wallace 2 Salvadore Cespedes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 8 Mauldin Avenue, North East, Maryland 21901 Judith L. Wrang/ Daughter January 6, 20b. Place of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State etery, cremetory or other piece) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Elkton Cemetery Elkton, Maryland 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921 eker 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onsat and Death Physician /Medical Immediate Cause (Final Coronary Artery disaase or condition resulting in death) Examiner Examiner The law requires that the death certificets be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last physician and s the bunal-tran Due to (or as a consequence of) Box 68760. Physician/Medicai Due to (or as a consequence of): as attending for usa as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed t Records, þ 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 s has certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

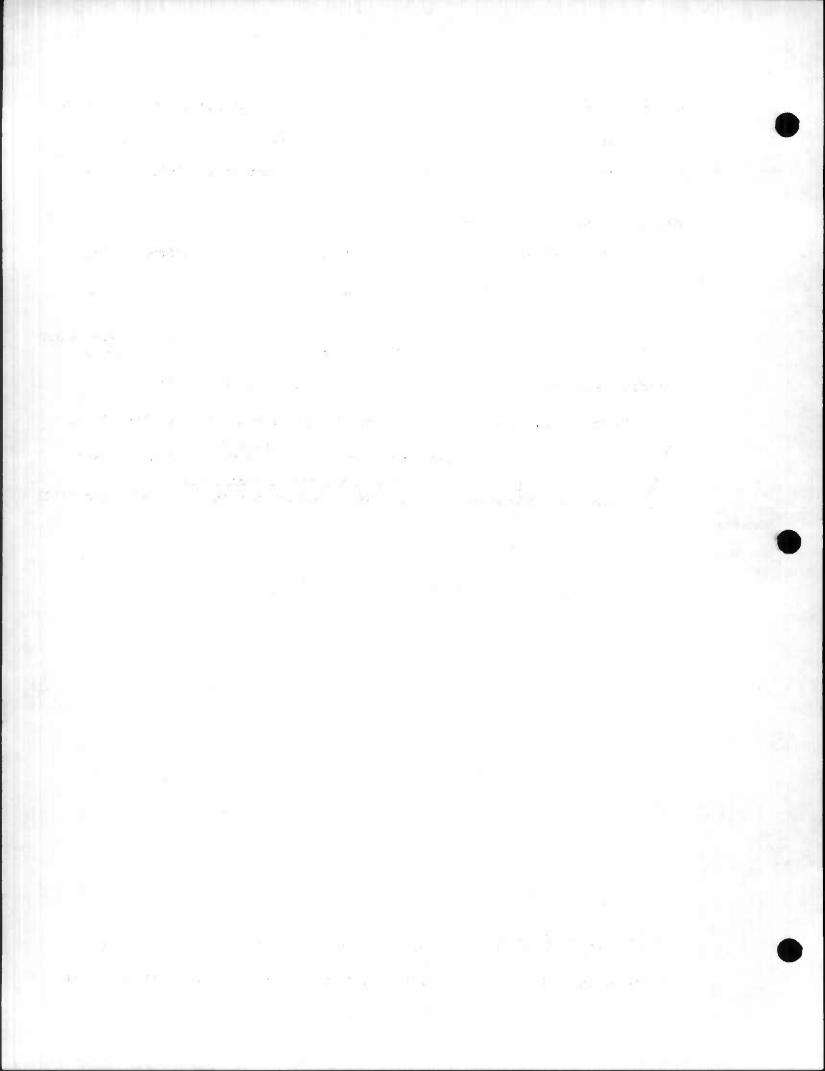
To the Funeral Director: After this certifica completaly filled in by the funeral director; § Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidenca 6 Othar (Specify) P 1 Nas 2 No Certification: 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Invastigation 1 Maturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowladga, death occurred at tha time, data and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) TIONGSON P0053309 30. Name and addless of person who completed cause of death (Item 23e) (Type, Print) Union Hospital of Cecil County, Elkton, Maryland 21921 Jeff Tiongson M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

JAN 05 1999

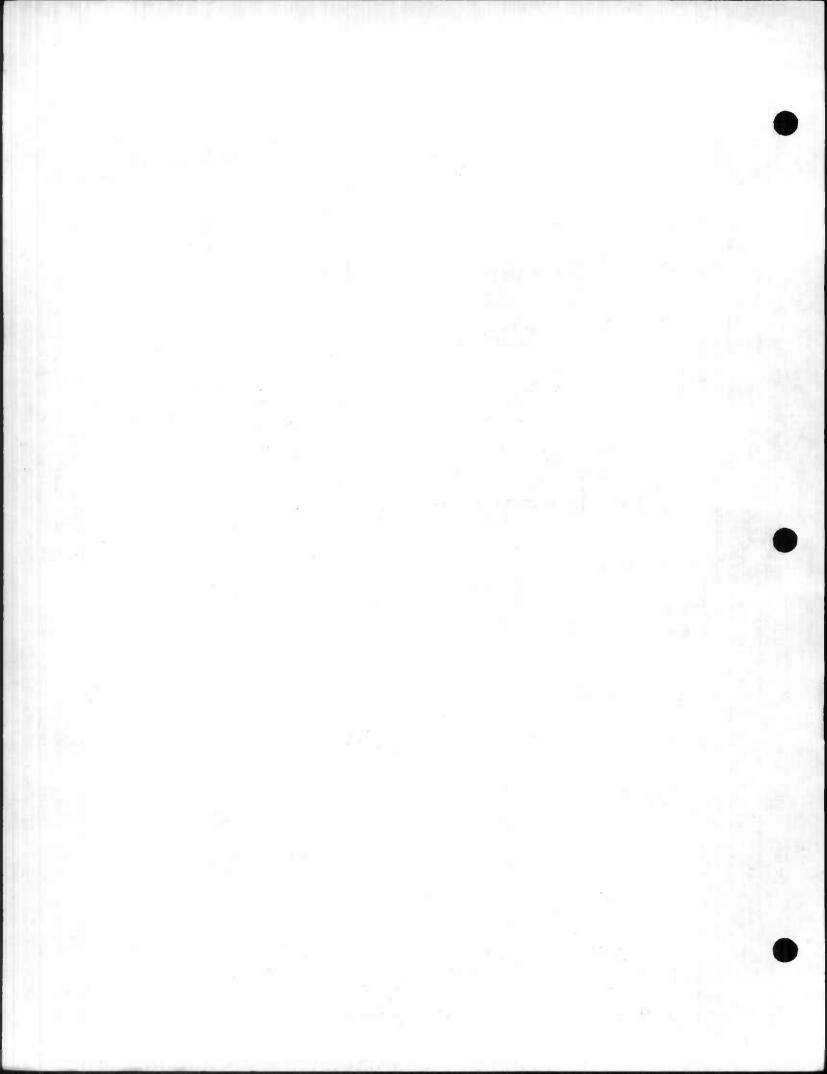


## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible 5 8 2 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** 5:00 AM Janet Marie Bates SMISKI /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Residence: 264 Doctor Jack Road Port Deposit Cecil If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F Months 214-54-2508 58 Director July 10, 1940 Pennsylvania Usual Residence of Decedent 10n. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 ☐ Yes 2 No Director Maryland Cecil Port Deposit 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Itama 23a or U.S.A. 264 Doctor Jack Road 21904 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ZX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Married Married Maryland 21215-0020 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Ten Years Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Department of Health and Mental Important: If New 27 is marked of 2 Gilbert Roby Elsie Engle 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Denver G. Bates (husband) 264 Doctor Jack Road, Port Deposit, Maryland 21904 Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 ABurial 2 Cremetion 3 Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) West Nottingham Cemetery 1/5/99 Colora, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licer Lee A. Patterson & Son Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Exemine 1050 0 the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) end physician Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 40 3 Probably 4 Unknown Division of Vital Records, þ Mors of Back and Alips 24b. Ware eutopsy lindings availabla prior to completion ol cause of death? Completed 24a. Wes an autopsy performed? Osteo perosu 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; Be 25. Was case referred to medicat axaminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation **Natural** 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Plece of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicel (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) who completed cause of death (Item 23a) (Type, Print) 8 2303 mas 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 5 1999 Registrar

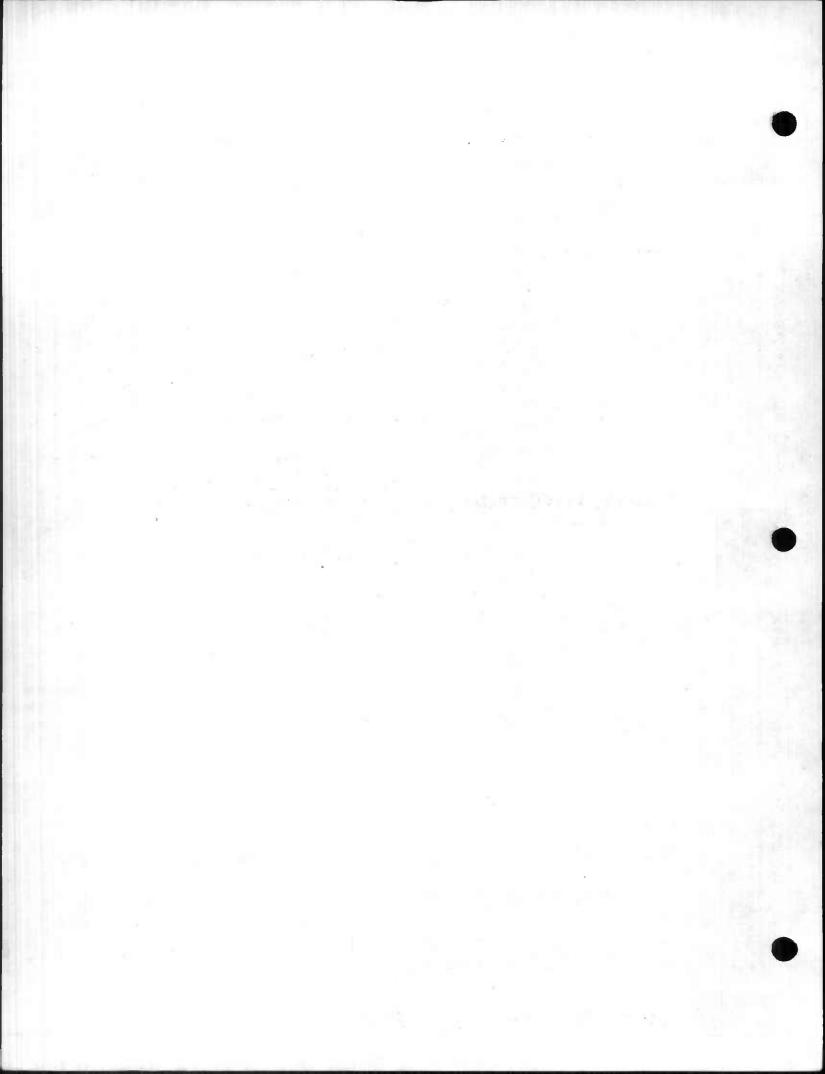


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene D Certificate of Death 2. Dale of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dey **Physician** January 3, 1999 1637 Ralph Windfield Hamm /Medical BRIA 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** XXM 2DF Months 228-306371 70 Director March 5, 1928 North Carolina Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No PRIMARY PHYSICIAN Directo Cecil Maryland Port Deposit 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3 Grimes Golden Drive 21904 U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? XX Yes 2 ☐ No 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married b 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 1948-50 Specify: by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry V.A. Medical Center Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Perry Point, Maryland Six Years Fire Fighter Maryland 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) 8 Pages 1 and 2 should be finent of Health and Mental I int: If Item 27 is marked or Arthur Hamm Pearl Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Stella M. Hamm (wife) 3 Grimes Golden Drive, Port Deposit, Maryland 21904 them 2. Baltlmore. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or = 5 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 1/6/99 Aberdeen, Maryland 22. Name end Address of Fecility 21. Signature of Funeral Service Licens Lee A. Patterson & Son Funeral Home DE Montal ! CHECKOK Perryville, Maryland 21903-0188 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a cooped EXPIRED Examine ellethia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical MINFIELD Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ò hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely fi (Check only one) ş 29b. Signature and title of certifier 29c. License number 29d. Daye signed (Month, Day, Year) Steam 30. Name and eddress of person who completed sause of death (Item 23a) (Type, Print) Brian T, Yeo, M.D., 801 South Union Avenue, Havre de Grace, Maryland 21078 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

JAN 05 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					C	Certificate	e of	Death		Reg. No.			
	Physic /Medi	_	1. Decedent's Name (First, Middle, La.  Elsic Janio						2. Dete of D Month	Dey	Year   3.	Time of Death	
	Examir		4e. Facility Neme (If not institution, give	pital				4b. City, Town, o		th 4c. County			
	Funerai Director		5. Sociel Security Number 6. S 043-49-1773	/	yrs. lest birtho	Months	1 Year Days		s. 8. Date of B (Month, D		9. Birthpiece Country)	(State or Foreig ansinc	
	with the Maryland ta or 28a-f show the notified at	ctor	Usuel Residence of Decedent  10e. Stete 10b. County  MD Ceci		C. City, Town o	r Location	7					nside City Limit	
	with the	I Director	10e. Street and Number 45 PatrickWo	ard Drive		10f. Zip		911		10g. Citizen of			
5-0020	72 hours after death natural", or items 23 ligal Examiner must	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U,S.	1	ent of I	lispanic Orlgin? ( an, Mexican, Pue	Specify Yes or N rto Rican, etc.)	14. Red Ble	ca - American Inck, White, etc.		
21215-0	within ena. than "r	Completed	15. Decadent's Ed (Specify only highest gre Elementary/Secondery (0-12)	ucation de completed) College (1-4or 5+)	- (G	ecedent's Usua Give kind of wor le. DO NOT us home	k done e retire	during most of w	orking		home		
Maryland 2	d 2 should be filed th and Mentel Hygi 7 is marked other traumatic event, II	To Be C	17. Father's Name (First, Middle, Last)  Clarence	Wilcox				18. Mother's No		e, Meiden Sumer	ne)		
imore,	permit. Pages 1 end Department of Health Important: If Itam 27 any injury or other to pages.		20a. Method of Disposition  1 Buriel 2 Cremation 3   4 Donation 5 Other (Specify  21. Signature of European Service Licen	Removal from State	COb. Placa of Dicametery,	isposition (Nem cremetory or or Ceme 22. Name an	d Addre	ce)	Dete Ce Fur	Elkton neral H	City or Town, s Mari	state	
	hysician /Medical		23a. Part1. Enter the the use, or compshock, or heart fallum. List only immediate Ceuse (Finel		death. Do not	enter the mode				Marylan arrest,	App Inte Ons	roximate rval Between et end Deeth	
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ox 68760,	centificate be executed adding physician and use es the buriel-transit	n/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Undertylving Cause (Disease or Injury that initiated events resulting in death) Lest	c. Mul	to (or as a con	nsequence of):		AMC	ETAST	W2/2	7.	cars	
P.0	ras mat me deam cel signed by the ettendir be datached for use	Part II. Other significant conditions contributing to death but not resulting in the underlying					inderlying cause given in Part I. 23b			tobacco use co		buta to the cause of death	
ords	s been s 2 should	Completed by						24a. Wa	s an autopsy formed?	availabl	utopsy findings e prior to tion of cause 1?		
al Re	ata h page								10	Yes 2 No	1 □ Yes	2 No	
Vital	s certificata director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	<u>~</u>		Oth	2001	eeth (Check only				
of	After thi funeral	27. Manner of Death  1 Divatural 5 Pending (Month, Day Year)  28b. Time of Injury  (Month, Day Year)  28b. Time of Injury  M  28b. Time of Injury  (Month, Day Year)  M						y at rk?   Yes 2 □ No	28d. Describe	eldenca 6 Oth	rred		
Div	Action of Attention 24 hours after death Funeral Director: etely filled in by the	dical Certif	4 Homicide determined  29e. Certifier 1 Certifying Phy	building, etc. (S	pecify) y knowledge, d	eeth occurred a	it the th	me, dete and place	City or To	(Street end Number, Stete)  e ceuse(s) end me date end place	anner as stated		

State Registrar

29b. Signeture and title of certifier

31. Date filed (Month, Day, Year)

David Gar. El

JAN 0 5 1999

MP

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

Avenue

3 Mauldin

29c. License number

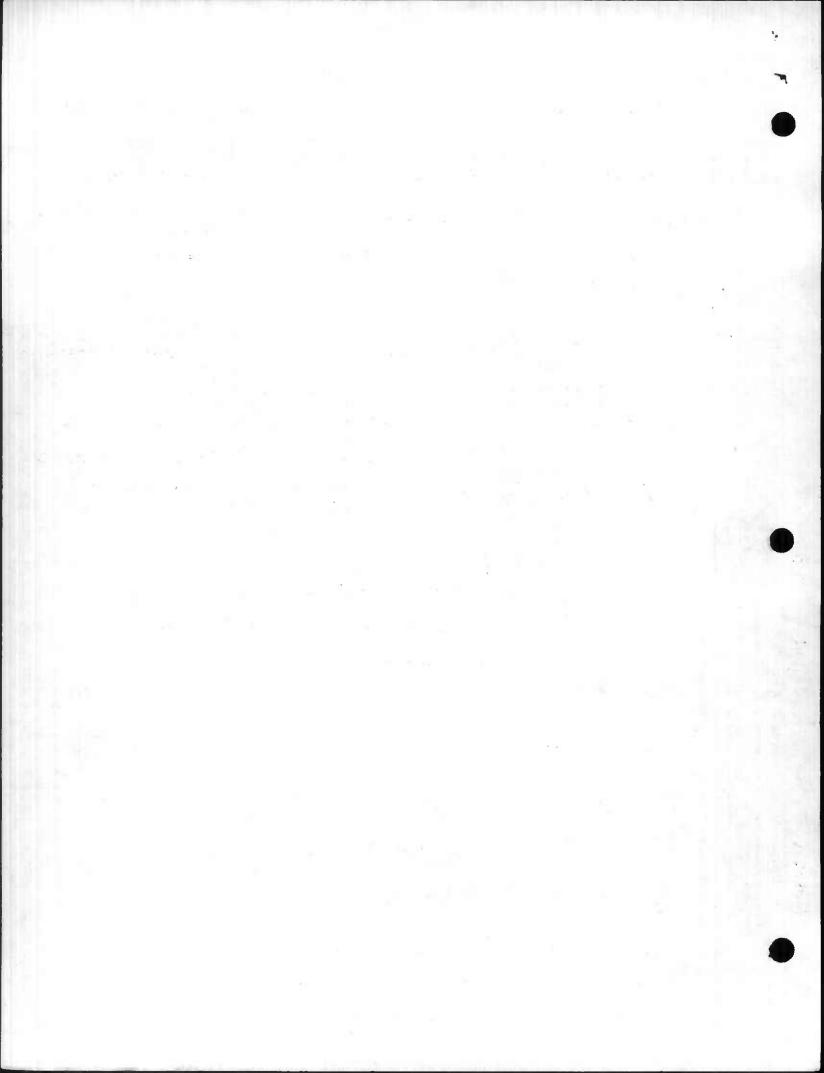
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29d. Date signed (Month, Dey, Year)

North East Maryland 21901

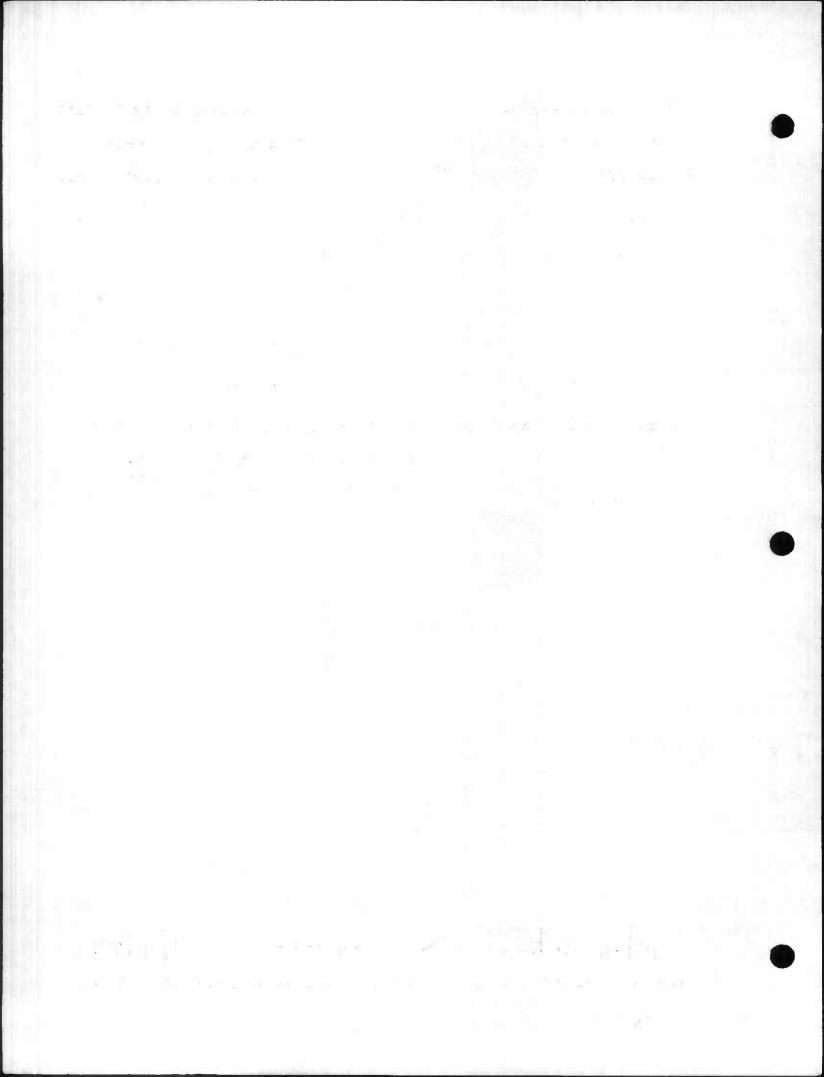
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aminer *	e. Fecility Neme (If not Institution, giv		er)			own, or Location of	Deeth 4	c. County of		
	36 Red Hill  Social Security Number 6.5		Ana //n sun land hinth	dev) If Under 1		cton	of Dist	Cec		
erai		M 2√2 F	Age (In yrs. lest birth) 88 Yr	Months D	eys Hours	Min. (Mont	of Birth h, Dey, Year	) 9.	Birthplece (State or Fore Country)	
	Isusi Residenca of Decedent	41	00			Novemb	per 2	4,191	0 Md.	
4	0e. Stete 10b. County	31-71	10c. City, Town	or Location					10d. Inside City Lim	
To Be Completed by Funeral Director	Md. Ce	cil	Elk	ton					1 Yes 2□I	
Director	0e. Street and Number			10f. Zip Co	ode		10g. C	itizen of Wha	at Country?	
9	36 Red Hill	Road			21921			USA		
Funeral	1. Maritel Stetus	12. Wes Decede	ont Ever In U,S.	13. Wes Deceden		igin? (Specify Yes n, Puerto Rican, etc			American Indian,	
T.	1 Never Married 2 Merried	Armed Force					>.)		White, etc.	
by	3 Widowed 4 □ Divorced	If Yes, Give Yeer or Dete	is:	1□Yes 2tX	No Specify:			Specify:	White	
Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. D	ecedent's Usuei C	occupation	et of working	16b. I	Kind of Busin	ness/Industry	
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Be 1	7. Fether's Neme (First, Middle, Last)			18. Mother's Neme (First, Middle, Meiden Sumame)						
2	Robert Goody	ear		Margaret Simpers						
	9a. Informent's Neme/Relationship (	treet and Numb	er or Rural Route N	lumber, City	or Town, Sta	ate, Zip Code)				
2	Chomas C. Hitch	hcock,		71 Sing	erly F	Rd., Elk	ton,	Md.	21921	
2	0s. Method of Disposition  1X Buriel 2 Cremetion 3	Removel from Sta	20b. Plece of Disposition (Name of cametery, cremetory or other piece)  20c. Locat						y or Town, Stete	
	4 Donation 5 Other (Specify		Elkto	n Cemet	ery	1/6/99	E11	cton,	Md.	
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	1 Fel - 11	11/1-		Gee Fu	neral	Home El	kton	Md.	21921	
	23a. Pert1. Enter the disease, or com shock, or heart feilure. List enly	plications that cause	sed the deeth. Do no	enter the mode o	f dylng, such ss	cardiac or respiret	ory arrest,		Approximete	
n	shock, or heart feilure. List only	one cause on eec	h line.						Interval Between Onset and Death	
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	sequentially list conditions, eny, leeding to immediate ause. Enter Underlying cause (Disesse or injury	C	A						1	
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Physician/M	ert ff. Other significant conditions of	ontributing to deet	but not resulting in ti	ne underlying caus	e given in Pert	1. 23b.	Did tobacc	o use contri	bute to the cause of dear	
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						24e.	Wes sn sut	16b. Kind of Business/Industry  Medical  Medical  Meiden Sumame)  Simpers  Jor. City or Town, State, Zip Code)  On, Md. 21921  20c. Location - City or Town, State  Elkton, Md.  E. Main St.,  Con, Md. 21921  Irrest,  Approximate Interval Between Onset and Death  Conset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  24b. Were autopsy finding svelisbe prior to completion of cause of desth?  Yes 2 No 1 Yes 2 No		
- Set							periorinear		completion of cause	
Completed							1 ☐ Yes :	TELNO.		
	5. Wes case referred to medical				OC Disc	and Darath (Charle		LINO	10 100 20 100	
(0)	exeminer?	Hospitei:	ation ADERIO	Heat 2 DOA	Other:	e of Deeth (Check	/	a 🗆 Out	(0===4.1)	
5 5 2	7. Manner of Death	28a, Date of I	atient 2 ER/Outp		1	ursing Home 5 28d. Desc			Specify)	
후	1 Neturel 5 Pending Investigation	(Month,	Dey Year) Inju	my M	Injury et Work? 1 Yes 2		111000000000			
fica	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office						tion (Street a	nd Number o	or Rural Route Number,	
T	4 Homicide determined building, etc. (Specify)						or Town, Sta			
	9a. Certifier 1 Certifying Ph	deeth occurred et the time, date and pleca, end due to the cause(s) end manner as stated.				er as stated.				
edical	29a. Certifier (Check only one) 1 Certifying Physicisn: To the best of my knowledge, 2 Medical Examiner: On the basis of examinetion end end menner steted.				nowledge, deem occurred or the time, date and pieca, and due to the cause(s) and manner as sisted. netion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause					
-	9b. Signeture and title of cartifier		2	29c. License number 29d. Date signed (Mo				Month, Dey, Year)		
	NIAM S	12/00	~~ ~	> bosso 34 114 9 9				99		
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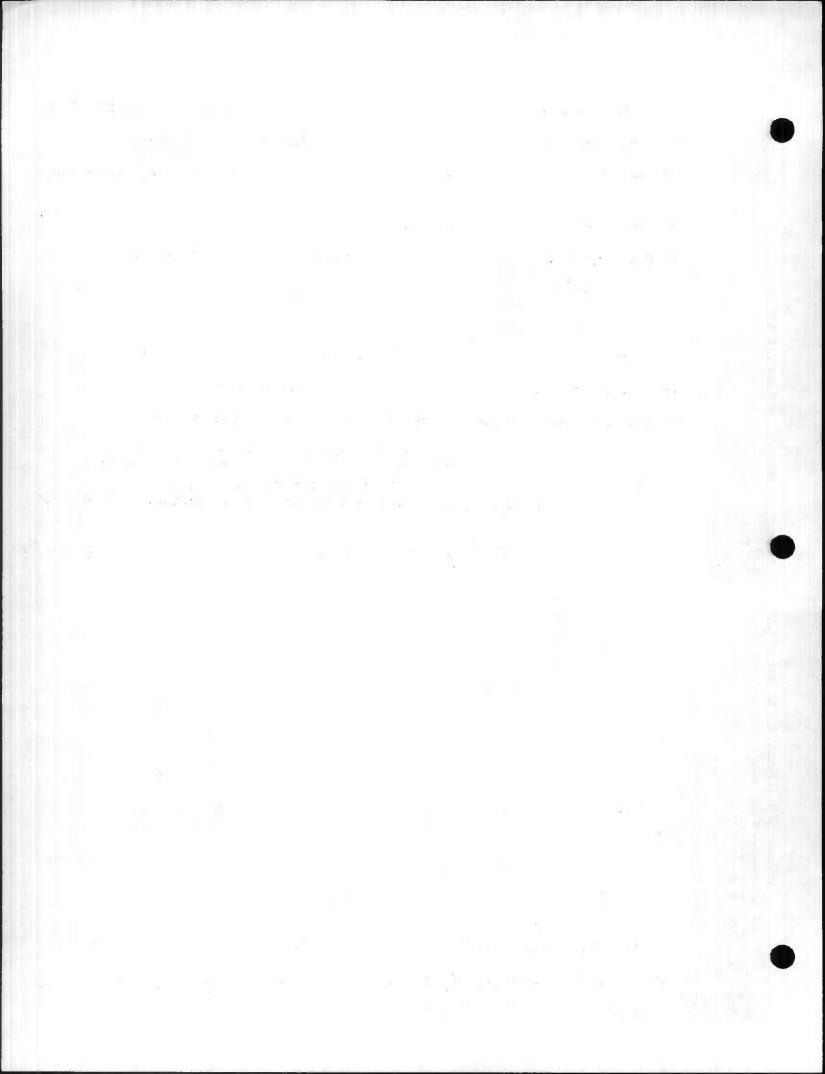
State Registrar



## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 0587

		State of Ivial	•	Certificat				Reg. No.		0007
Physician	1. Decedent's Name (First, Middle, Las	1)					2. Dete of De Month	Dey .	Yeer	3. Time of Death
/Medical	Sandra F. Eshleman						Janu	ary 1	1999	18:42
Examiner	4a Fecility Name (If not institution, give	street and number)				4b. City, Town, or L	ocation of Deet	h 4c. County	of Death	
AU	103 Cambridge Road					Elkton		Cecil		
Funeral Director	5. Social Security Number 6. Sec. 10	7. Age	(In yrs. last birth 52	Months		if Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De	y, Year)		lece (Stete or Foreign try) sylvania
g	Usuel Residence of Decedent  10a. Stete 10b. County		10c. City, Town	or Location						0d. Inside City Limits
vith the Maryl s or 28a-f sho be resulted	Maryland Cecil		Elkton							1 ☐ Yes 2 🔀 No
th the second	10e. Street and Number			10f. Zip	Code			10g. Citizen of \	Whet Coun	try?
h wil					2192	21		United S	State	S
within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-1 show the Machine restriction.	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:	1011	13. Was Deced If Yes, spec		lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)	Specify	ck, White, Wh.	
ges 1 and 2 should be filed within 72 hours aft to Health and Mental Hygiene. If Item 27 is marked other than "natural", or or other traumatic event, the Medical Energy or Other To Be Completed by F	15. Decedent's Ed (Specify only highest gree	fe completed)		Decedent's Usua Give kind of wo life. DO NOT u	rk done	during most of world	king	16b. Kind of B	usiness/Inc	lustry
within within	Elementery/Secondary (0-12)	Coilege (1-4or 5+		f Emplo	hev			Craft		
Hygin Hygin			per	r mubro	yeu	18. Mother's Nen	ne (First, Middle		ne)	
d be fill mital H cover						Mabel	Ammon			
aryland 212 should be filed with and Mental Hygiene. s marked other than umatic event, treat	19a. Informent's Neme/Relationship (7		19h I	Mailing Address	(Street	end Number or Ru		er. City or Town	Stete. Zin	Code)
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e, N 1 and 1 Health am 27 other tr	20e. Method of Disposition	ii/ iiusbaiia		Disposition (Ne	_	Moda, III	Date	20c. Location		
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E. Pe tant: tant: jury	4 Donation 5 Other (Specify		Cemeter	У			1999	Penns	ylvan	ia
Description  Permit. Per Department Important: any Injury page.	21. Signature of Funeral Service Licens	3		22. Name er Hicks H	d Addre	for Fune	rals, P	.A.		
4 405 6 4	Daniel &	3. Hick				tockton S			aryla	nd 21921
	23e. Pert1. Enter the diseese, or comp shock, or heert feilure. List only	lications that caused to one cause on each line	he deeth. Do no	ot enter the mod	le of dyl	ng, such es cardiac	or respiratory e	rrest,		Approximete Intervel Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Cholan	g'o Co	onsequence of)	) m	٤				6 mon As
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ificate be executed gphysician and as the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	ue to (or as e co	onsequence of):					1	
cata be exphysician si the buria	Cause. Enter Underlying Cause (Disease or Injury that initiated events	c								
as a diff			ue to (or as a co	nsequenca of):						
eath certi ettending I for use a		d								
the death centry the ettending white ettending sched for use thy sician.	Pert II. Other significant conditions co	ntributing to death but	not resulting in	the underlying of	ause gi	ven in Pert I.	23b. Dld	tobacco uae co	entribute to	the cause of death?
							10	Yes 2 No	3 Pro	bably 4 Unknow
The law requires the rate has been signed page 2 should be de Completed by F			4					s an autopsy ormed?	av co	ere autopsy findings eilable prior to mpletion of cause deeth?
F 2 2 0							10	Yes 2 No		Yes 2 No
VICION: The certificate rector, pag	25. Was case referred to medical					26. Plece of Dea	th (Check only	one)		
hysici his ce il direc		Hospital: 1 Inpatient	2 ER/Out	patient 3 De	OA Ot	her: 4 Nursing H	ome 5 Res	idenca 6 🗆 Ott	her (Specif	(y)
offing Ph. Affer th funeral	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey	Year) 28b. Tii	me of iury M	28c. Inju Wo	ry et ork? ] Yes 2 □ No	28d. Describe	how injury occur	rred	
DIVISION OF VITAL RECORDS,  To the Hospital or Attending Physicien: The law requires the within 24 hours effer death.  To the Funeral Director: Affer this certificate has been signed completely filled in by the funeral director, page 2 should be Medical Certification: To Be Completed by	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injur building, etc.		m, street, factor	y, office			(Street and Num. own, Stete)	ber or Run	al Route Number,
n 24 hours n 24 hours ne Funera pletely fille		raician: To the best of iner: On the basis of e and manner state	xamination end/							
outho omple		/		29	c. Licen	se number		29d. Dete signe	ed (Month,	Dey, Year)
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10	30. Neme and eddress of person who d	completed cause of dee	oth (ttem 23e) (T	ype Print)	U	se number 153 e sapeuk	e Hosp	ice. E	1kTc	m mi
State	31. Dete filed (Month, Dey, Year)	32. Registrar	s Signetule	Low	11		11 1			, ,



Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 1999 SCOTT DOUGLAS PARKER Jan. 10:24 am /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner CIVISTA MEDICAL CENTER La Plata Charles H Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min.

June 9,1960 5. Sociel Security Number 6. Sex 1X M 2 ☐ F 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Yrs. 38 Washington DC 219-78-6582 Director Usual Residence of Deceden with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinet mast be notified at Yes 2 No Director MD Charles La Plata 10e. Street and Number 10f Zin Code 10a. Citizen of Whet Country? 20646 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a pages. 306 Prince Georges Street Funeral 12. Was Decedent Ever In U,S Armed Forces? 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck White etc. 1 ☐ Yes 2 XNo 1 Never Married Married 1 ☐ Yes 2 X No Specify: Specify: White by 3 Widowed 4 Divorced Yeer or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Lab Technician Power Plant 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Joyce Pickett Parker Benny Roden Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Kimberly Parker/Wife 306 Prince Georges St. La Plata, MD 20646 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from Stete Trinity Memorial Gar. 1/6/99 Waldorf, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Fecility of Funeral Service Licenses MUO945 AREHART-ECHOLS FUNERAL HOME P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical · CANCE OF Examiner Due to (or es a consequence of) Examiner physician and is the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): attanding signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yaa 2 No by 24b. Were sutopsy findings aveileble prior to 24e. Wes en eutopsy Completed been : completion of ceuse of death? page 2 s has 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: after death. 25. Wes case referred to medical examiner? Be 28. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 20 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 2☐ EB/Outpetient 3□ DOA this funeral 28b. Time of 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: Director: After 5 Pending 1 Yes 2 No investigation 6 Could not be determined n 24 hours after der ne Funeral Directo bletely filled in by th 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and placa, and due to the cause(s) end manner stated. edical 29e. Certifier (Check only one) To the within 2 29d. Dete signed (Month. Dav. Year) 29b. Signature end title of certifier 29c. License number D-28352 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

Krishan Mathur, MD 3500 Old Washington Rd. #102 Waldorf, MD 20602

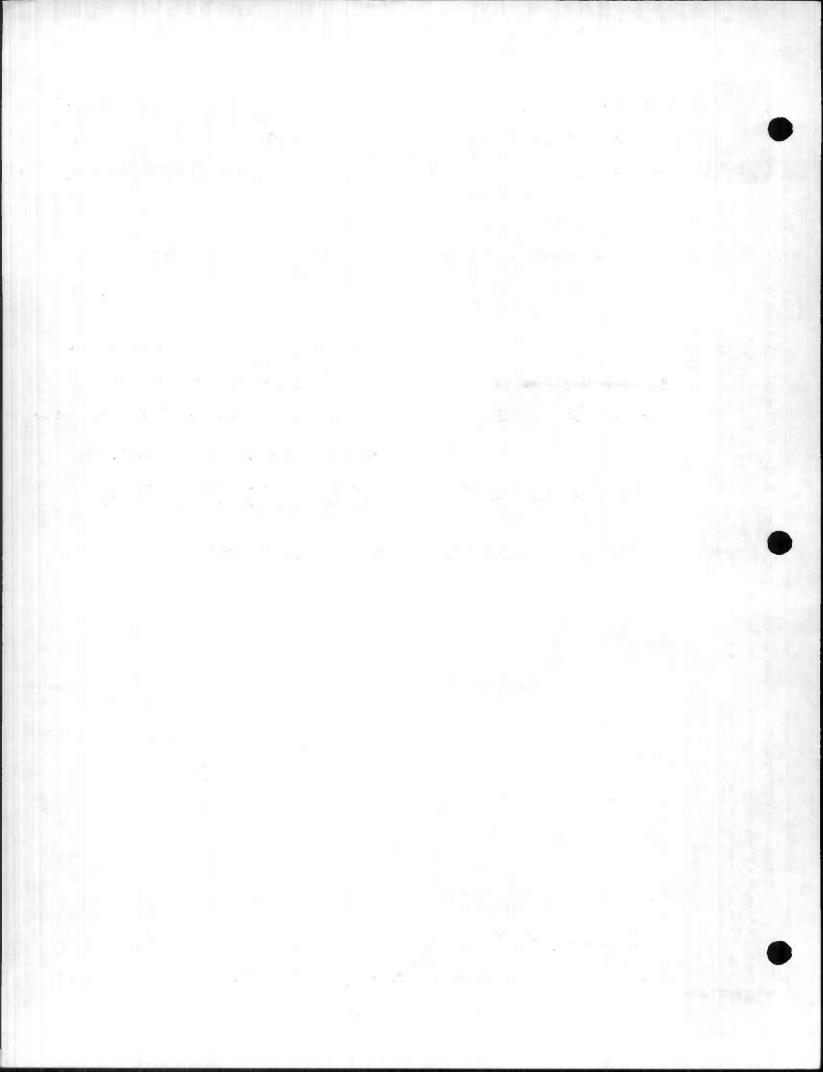
32. Registrar's Signature

State Registra

31. Date filed (Month, Dey, Yeer)

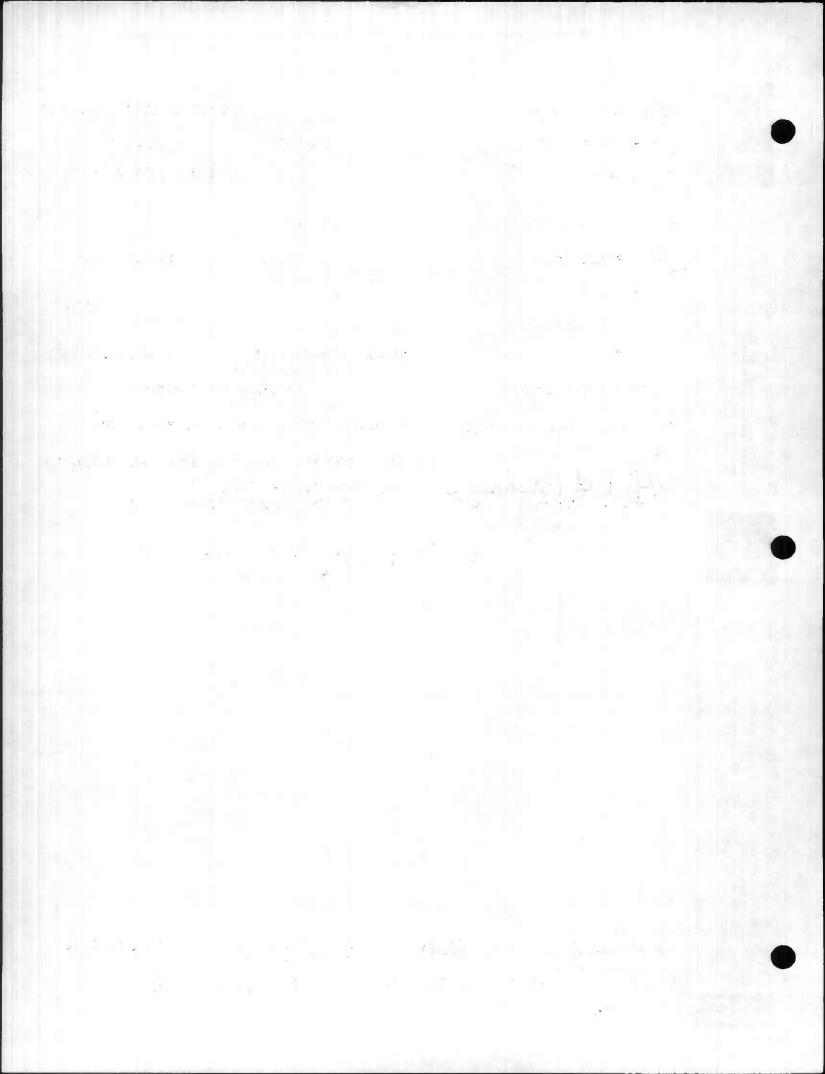
JAN 05

1999



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			C	ertifica	te of	Death		R	leg. No.			
	1. Decedant's Nama (First, Middle, La	ast)						2. Data of Dea			3. Tima of I	Death
Physician	RENEE CAROL EP	PARD						Month JANUARY	3. 199	Yaar	4:30 A	ΔM
/Medical	4a Facility Nama (If not institution, gir					4b. City, To	wn, or Lo	ocation of Death	4c. County	-	T + 30 P	11.1
Examiner	4770 HARRIER COU					LIAT DO	AD E					
			a /la um lant histhal	If I Ind	ar 1 Yaar	WALDO if Undar		8. Data of Birth	CHAR		dana /Ctata an	. Casain
Funeral	A SECOND	ITM ATVE	a (In yrs. last birthd	Months			Min.	(Month, Dey APRIL 3	Year)	9. Birth	olaca (State or otry)	Foreign
Director	212-66-3486		45 Yrs					APRIL 3	0, 1953	WAS	HINGTON	4 DC
P .	Usual Rasidence of Decedent  10a. Stata  10b. County		10c. City, Town o	r Location						Τ,	Od. Insida City	v Limite
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th wi	4770 HARRIER COU	RT				206	503		UNITE	D ST.	ATES	
frar death v	11. Marital Status	12. Was Dacedant		3. Was Dec	edant of	Hispanic Or	Igin? (Sp	ecity Yas or No-			cen Indian,	
or he	1 Navar Married 2 Marriad	Armed Forcas?						Rican, atc.)	Bled	ck, Whita,	atc.	
	3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva Yaar or Datas:		1 🗆 Yas	2LX No	Specify.			Specify		WHITE	
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should be and Mental marked of matic ev	LAWRENCE JAMES C							ED ADELE				
0 0 0	19a. Informant's Name/Relationship	(Type, Print)	19b. M	eiling Addre	ss (Stree	t end Numb	er or Rur	a <i>i Route Numbe</i>	r, City or Town,	State, Zip	Code)	
1 and 2 Health em 27 i	BRUCE ALAN EPPAR	D - HUSBAN	D 4770	HARR	IER (	COURT,	WAI	DORF, M	ARYLAND	20	603	
	20a. Mathod of Disposition		20b. Plece of Di	sposition (N	eme of	rca)		Data	20c. Location -	City or To	own, Steta	
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Departm Departm Importan any injur	21 Signature of Furlaral Sarrice Loa	Michall	w	THE H	JNTT	FUNE	RAL F	HOME, IN	C.			
20240	MARK G. BROH		53	P.O.B	OX 15	56, WA	LDOF	RF, MARY	LAND 2	0604		
_	23a. Part1. Entar tha disaase, or con shock, or heart failura. List only	nplications thet causage on a ech li	tha daath. Do not na.	antar tha mo	oda of dy	ing, such es	cardiac	or respiratory an	rest,		Approximata Intarval Betw	vaen
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has b									1	Of	daath?	
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Physician: this cartific ral director,	25. Was casa rafarrad to medical axaminar?					26. Plac	e of Daat	th (Check only o	ne)			
hysic nis ca il dire	1 Yas 2 No	Hospital: 1 Inpatie	ant 2 ER/Outpa	itient 3 🗆 t	DOA O	har: 4 N	ursing Ho	ma -5 Pasid	lance 6 Oth	ar (Speci	fy)	
a Ph	27. Manner of Death	28a. Date of Inju	ry 28b. Tim		28c. Inju	ry at		28d. Dascribe h	ow injury occur	red		
th. After of funding	1- Natural 5 Panding Investigation	(Month, Da	y Year) Inju	M		Yes 2	No					
tal or Attending P rs aftar death. al Director: After t led in by the funere Certification:	2 Accident Investigation 3 Suicide 6 Could not be							28f. Location (S	Straet and Num!	ber or Run	al Route Numb	ber,
or long line long long long long long long long long	28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)							City or Tow	m, Stete)			
The state of the s	P											
in 24 hour he Funer pletely fill edical	(Check only 2 Medical Exa	hysician: To the bast minar: On the basis o	of my knowledga, d f axamination and/o	aath occurre r invastigatio	d at the t	ime, dete er opinion, dar	nd plece, ath occur	end due to the or red at tha tima.	cause(s) end mo data and place.	and dua t	stated. o tha causa(s)	
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Ceri	one)	and mannar st	atad.									
To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this cartificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	29b. Signatura and titla of certifiar	7.45		2	9c. Lican	sa number		3	29d. Deta signe	d (Month,	Dey, Year)	
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	30. Nama and eddress of person who	completed assess of a	leath (Item 22a) /T-	ne Print)	0	0 )	) .			1	1	
	D.O. Rama and educess of person who	2011 Please of C	) (Ty	Pe, Pint)	1	A -0		206	111			
	21 Date filed (Manth Com Vani	7 5 6	ada Sin-	LC1	1	14		5-6	46			
State	31. Data filad (Month, Day, Yeer)	32. Hagistr	ar's Signatura	S	1	th						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth ESTELLE BERRY JAN VIOLEI 11:35 AM 4e. Facility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGE'S 8. Date of Birth (Month, Dey, Year) 5. Social Security Numbar If Under 1 Year If Under 24 Hrs. Hours Min. 6. Sax 7. Age (In yrs. lest birthday) Birthpiaca (State or Foreign
Country) 1□M 2K F Months Days 213-48-3853 76 JUNE MARYLAND 1922 Usual Rasidence of Dacedant 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 Yas XX No MARYLAND CHARLES WALDORF 10e. Straat and Number 10f. Zip Coda 10g. Citizen of What Country? 11380 RABY ROAD 20601 UNITED STATES 12. Was Dacedant Ever in U.S. 11 Maritel Stetus Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxicen, Puerto Rican, atc.) Reca - Amaricen Indian, Biack, White, etc. Armed Forces? 1 Never Marriad 2 Married 1 ☐ Yas 2 No Specify: Specify WHITE 15. Decedent's Education (Specify only highast grade complated) 18e. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 10 HOMEMAKER OWN HOME 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Sumema) JOSEPH OLLIE DEMENT ESTELLE S. JENKINS 19a. Informant's Name Hationship (Type, Print) 19b. Melling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) ARNOLD - SISTER MARY S. 395 PHIRNE ROAD, GLEN BURNIE, MARYLAND 21061 20a. Mathod of Di 1 2 Burial 20b. Placa of Disposition (Nema of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 4 Dogat TRINITY MEM. GARDENS, JAN. 5, 1999, WALDORF, MARYLAND FUNERAL HOME, INC. MARK BROHAWN M00053 P.O.BOX 156, WALDORF, MARYLAND 20604 G. 23a. Part1. Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on sech line. Approximate Intervel Batween Onsat and Death CARDIORESPIRATORY Immediata Cause (Final disaasa or condition resulting in daath) RDS Dua to (or as a consequence of): Sequantially list conditions, if any, laeding to immediata ceuse. Entar Underlying Ceuse (Diseasa or injury that initieted avants resulting in death) Last FAILURE Dua to (or as e consequance of): EFFUSION Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 25 No 3 Probably 4 Unknown 24b. Wara autopsy findings avellabla prior to complation of cause of death? 24a. Was en autopsy performed? 2 No

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f show ad cal Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours eiter Depertment of Healin and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Eventries

Baltimore, Maryland 21215-0020

Funeral Director

Be Completed by

death with the Maryland

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Attending Physician: The law requires that the death cartificate be executed

death.

Hospital of the Hours B To the Hospital within 24 hours a To the Funeral C completely filled

spital or Attendi lours effer death heral Director: A filled in by the f

P.O. Box 68760,

Division of Vital Records,

Physician/Medical Examiner

þ

Completed

Be

Certification: To

Medical

1 Natural

2 Accidant 3 Sulcida

4 Homicide

25. Was cesa referred to medicel axaminar?
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investigation

6 Could not be datarmined

1 Yas

1 ☐ Yas 2 ☐ No

26. Placa of Death (Check only ona)

Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 28d. Describe how injury occurred

28a. Deta of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

29a, Certifian Certifying Physician: To tha best of my knowledge, deeth occurred at tha time, data and place, and dua to the causa(s) and manner as stated. ☐ Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signettiffered the of certifier

no

29d. Data signed (Morth, Day, Year)

30. Nama and eddrass of person who complated ceusa of daath (Itam 23a) (Type, Print)

GONSALVES, MD, 6 POST OFFICE ROAD #100, WALDORF, MARYLAND 20602 ANNETTE C.

State Registrar 32. Registrar's Signatura

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	- 0	Decedent's Name (First, Middle,	( ant)	Ce	rtificate of	Deam	1	eg. No.		
Physic				CD			2. Dete of Daat Month	Dev	Year 999	3. Tima of Death
/Med		GODFREY NOL  4e. Facility Name (If not institution,		SR.		4h City Town or	January Location of Deeth	4c. County		4:30am
Exami	ner	GENESIS ELDER								
Funeral				ge (In yrs. lest birthday)	If Under 1 Yaar		8. Dete of Birth	CHAR		laca (State or Foreign
Director		220-26-6575	1 € M 2 □ F	66 Yrs.	Months Days	Hours Min	MAY 19,	1932	MARY	LAND
pu .		Usual Residence of Decedent  10e. Stete 10b. County		40- 0h T						
anylan show	2			10c. City, Town or Lo	ocation				1	0d. inside City Limits 1 ☑ Yes 2 ☐ No
the N	Director	MARYLAND CHAR  10e. Street end Number	LES	WELCOME	404 71- 0-4-					
ti vit		8205 HARRY WAR	DEN DIACE		10f. Zip Code 206	0.2	1	Og. Citizen of V		
Jeath Tre 23	Funeral	11. Maritai Status	12. Was Decedent	Ever in U.S. 13.	Wes Decedant of I		Specify Yea or No-	UNITED	SIAI a - Americ	
d within 72 hours efter death with the Manyland glene. In than "natural", or flems 23a or 28a-f show in than "natural", or flems that be truited.	by	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forcas	No	If Yes, specify Cub 1 ☐ Yes 2 ☒ No	an, Mexican, Puer	to Rican, atc.)		k, White,	etc.
72 hours natural',	Completed	15. Decedent'a		16a. Dece	dent's Usuai Occup	petion	etcin o	16b. Kind of Bu	siness/ind	dustry
within jiene. r than	npie	Elemantery/Secondery (0-12)	College (1-4or	D+)	kind of work done DO NOT use retire		rking			
filed within Hygiene. ither than	Co	12th		SECUR	CITY GUAR					ICES ADMIN
S la b	Be	17. Fethar's Name (First, Middla, La	s()				me (First, Middla, M		0)	
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d 2 and 1 an		BRENDA WARREN-ED					urel Route Number			
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permit. Peg Department Important: I any Injury o		21. Signetura of Funarai Sarvice Lic		ZION BAPT	2. Nema and Addra	on of Facility	1/8/99 W			
permit. Departr Imports any Inju		From J	low	_	439 LIVI		THORNTON			
		LEON THORNTO  23a. Pert1. Enter the disease, or co ahock, or heart feilure. List on						AN HEAL	, MD	20640 Approximate
flicete be executed  physician and set the buriel-trensit	edical Examiner	diseesa or condition resulting in deeth)  Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in deeth) Last	6. ENJ	Due to (or aa e consec	RD1	ΠS			F	EW WKS
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eath certification of for use eath	lan									
it the death certi by the ettending teched for use	Physiclan/M	Pert ii. Other significant conditions	contributing to death b	out not resulting in the u	nderlying cause given	ven in Pert I.			ntributa to	the cause of death?
signed by	by Pt	LLVER 1	META.	STASI.	S		1 🗆 Ye	s 2 No	3 Prot	bably 45 theknown
s been 2 shoul	Completed b	CARCINOI	MA	COLON	)		24e. Wea er perform		evs cor	ere autopsy findings allebia prior to appletion of cause death?
0 - 0	E O						1□ Ye	s 2000		Yes 2□ No
delan: The	Be	25. Wes case referred to medical				28. Piace of De	eth (Check only on	9)		
0 0	10	exeminar? 1 ☐ Yes 2 ☐ No	Hospitel: 1 Inpatie	ent 2 ER/Outpetier	nt 3□ DOA OH		Homa 5 ☐ Reside		er (Specify	1)
ding Ph h. After th funeral		27. Manner of Death 1 ☐ Naturel 5 ☐ Pending	28e. Dete of Inju	y Year) 28b. Time of Injury	28c. Inju		28d. Deacribe ho			
or Attending efter death. Director: After	catl	2 ☐ Accident Investigat				Yes 2□No				
5 th 5 =	Certification:	3 Suicide 6 Could not determine	building, at				28f. Location (St.	, Stete)		
Mospital 24 hours Funeral letely filled	edical	Medical Ex	Physician: To the best aminer: On the basis o	examination end/or inv	occurred et the time estigetion, in my o	me, dete and plece ppinion, deeth occu	e, end due to the ce urred et the time, de	use(s) end me ete end piace.	nner ea st	eted. the cause(s)
within 2 To the comple	Med	29b. Signature ero lillie of certifier	end menner st	eted.						
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		20 Nome on Aldress	a complete the second							
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-the hough after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2,	De mied writin 72 nours arter death writi the begin, of meann and memtal hyghere proor to buhat, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING P	TO THE FUNERAL DIRECTOR, After 1	De nied within 72 hours affer ceath	IMPORTANT: If item 28 Is mar	

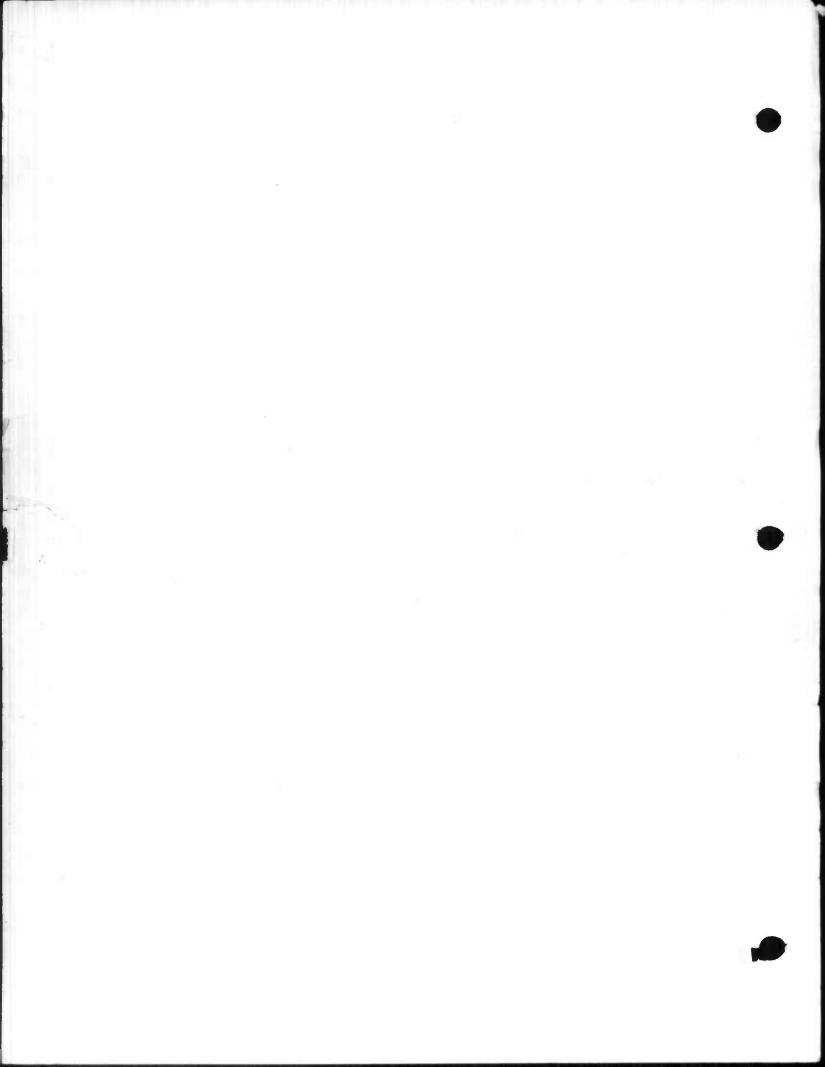
BALTIMORE, MARYLAND 21215-0020

3 should

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)						DEA		2. DATE OF	DEATH			3. TIME OF DEATH
	Grace	Marie	Ament							MONTH,	11	19	199	7:45 P. M
	4. SOCIAL SECURITY NUME		S. SEX	6. AGE (In yrs.	lest birthday)	IF UNDER		IF UNDER		7. DATE OF			a. BIRTH	IPLACE (State or Foreign
	214-74-5268		1 □ M X\ F	10	)3 YRS.	MONTHS	DAYS	HOURS	MIN.	NOV.	29,18	395	Mary	and
_	90. FACILITY NAME (If not in					9b. CITY			ON OF DE				UNTY OF D	
DIRECTOR	The Wesley	Home,	Inc.				Balt	imor	`e			1	A/N	
EC	10a. STATE	10b. COUNTY			10c. C/1	Y, TOWN (	OR LOCAT	ION						10d, INSIDE CITY
6	Maryland	c	N/A			Bal	timo	ore						LIMITS?
IA!	10e. STREET AND NUMBER		~~				101	. ZIP COD				10g. CI	TIZEN OF W	YHAT COUNTRY?
FUNERAL	The Wesley	Home,	2211 W	<ul> <li>Roger</li> </ul>	's Ave	enue			2	21209				USA
J.	11. MARITAL STATUS  1 Never Married 2	Merried	12. WAS DECEDEN FORCES? 1	YES XX		13.	WAS DEC	ENDENT (	OF HISPAN	IIC ORIGIN? (S	ipecify Yes n, etc.)	or No-	14. RACE Black	— American Indian, c, White, atc.
BY	3XX Widowed 4 Divo		IF YES, GIVE V	AR OR DATES			1   YES	2 X NO	Specify	c:			Speci	" white
ED	15, DEC	EDENT'S EDU	CATION COMPRISED	16a. I	DECEDENT'S	USUAL O	CCUPATIO	ON		16b. Kil	NO OF BUS	INESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (C	7	College (1-4 or 5	9	(Give kind of life. Do NOT u		auring ma	at or wondi	ng					
MP	8			HC	memak	er					In Ow	-	ome	
	17. FATHER'S NAME (First, M	,,	eaffer							ME (First, Midd				
BE	19a. INFORMANT'S NAME (7		currer	1	19b. MAILING	ADDRESS	S (Street o			K. Be			in Cadal	
2	Peggy Bout	chyard	Daught	er						Mait				1
	20e. METHOD OF DISPOSIT	ION	aumi dan — Stata	20b. PLAC	FANDDATE	OF DISPOS	ITION /Na	ma of			_		- City or To	
	4 Donation 5 Other	(Specify)		More	and	Memo	<u>rial</u>	Par	k	1/15	Par	kvil	le.	Maryland
	21. SIGNATURE OF FUNERA	L SERVICE LIE	opteste	~ 7	/	22.	NAME AF	O ADDRE	SS OF FAC	CILITY				-
	Ofla	Up T	t. La	Alul	u	3	631	Fall	s Ro	ad Bal	ii HO timo	me,	Mary	land 21211
	23. PART I. Enter the dishock, or h	laseses, or o	complications the	ceused the	death. Do	not enter	the mo	de of dy	ing, auci	h as cerdiac	or respi	ratory a	rreat,	Approximate
	IMMEDIATE CAUSE (FIR							η						Interval Between Onset and Death
	disease or condition resulting in death)	$\rightarrow$	. acuto	2 /cer	piral	ory	10	ull	ure.					A cult.
_		_	Endo	- CAD AD	Cla M	F): ().	Na	May not	1110	0.10	. (	. 7	) want	A cute.
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3	cause. Enter UNDERLY! CAUSE (Disease or Inju	ING	с											
E	that initiated events resulting in death) LAS		DUE TO	(OR AS A CONS	EOUENCE O	F):								
5			d											
- 11	PART II. Other algnifice					in the un	derlyin	ceuse (	given in	Part I. 24	. WAS AN		24b.	WERE AUTOPSY FINDINGS
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Σ										×/	-	1		1 TES 2 NO
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PHYSICIAN:	EXAMINER?	O MEDICAL	HOSPITAL:		ACE OF DEA	OTAE	3:							
¥ I	27. MANNER OFFICEATH		1 Inpatient 2 I		28b. TIM		28c. INJ		sidence	6 Other (Sp 28d, OESCRI		CHIBY OC	CUBEO	
		Pending Investigation	(Month, D	ay, Year)	IN	IURY M	WO	RK? ES 2	NO	2001 0200111	DE 11011 II		CONEO	
0 84	3 Suicide	Could not be	28e. PLACE O	F INJURY — At I	home, ferm,	street, lact	ory, offic			28f. LOCATIO		nd Numbe	r or Rumi A	loute Number,
E	4 Homicide	determined		- Copouny)						City or it	wn, State)			
립			CIAN: To the best of											
COMPLETED	one) 2 MEDI	CAL EXAMINE	R: On the basis of a	temination end/o	r Investigation	n, In my o	pinion, d	eath occur	ed at the	time, data and	place, end	due to t	he ceuse(e)	) end menner se stated.
BE	296. SHOWARUSE AND TITLE	OF CENTIFIE	21	. 7				29c. LICE	NSE NUM	BER		29d. DAT	TE SIGNED	(Month, Day, Year)
p P	covery	c. /	ough	1.D.				D	-149	125		> /	1121	11999
	30. NAME AND ADDRESS OF		DVV AA 9	SE OF DEATH (IT			16.10	n (	N 1/10		R	10)	MAD	7 n. 0
-	31. DATE FILEO (Month, Day,		32. REGISTRA	R'S SIGNATURE	-11 11	Soar	va E	الميا	HYC		UR	VIU,	IVID	6/207
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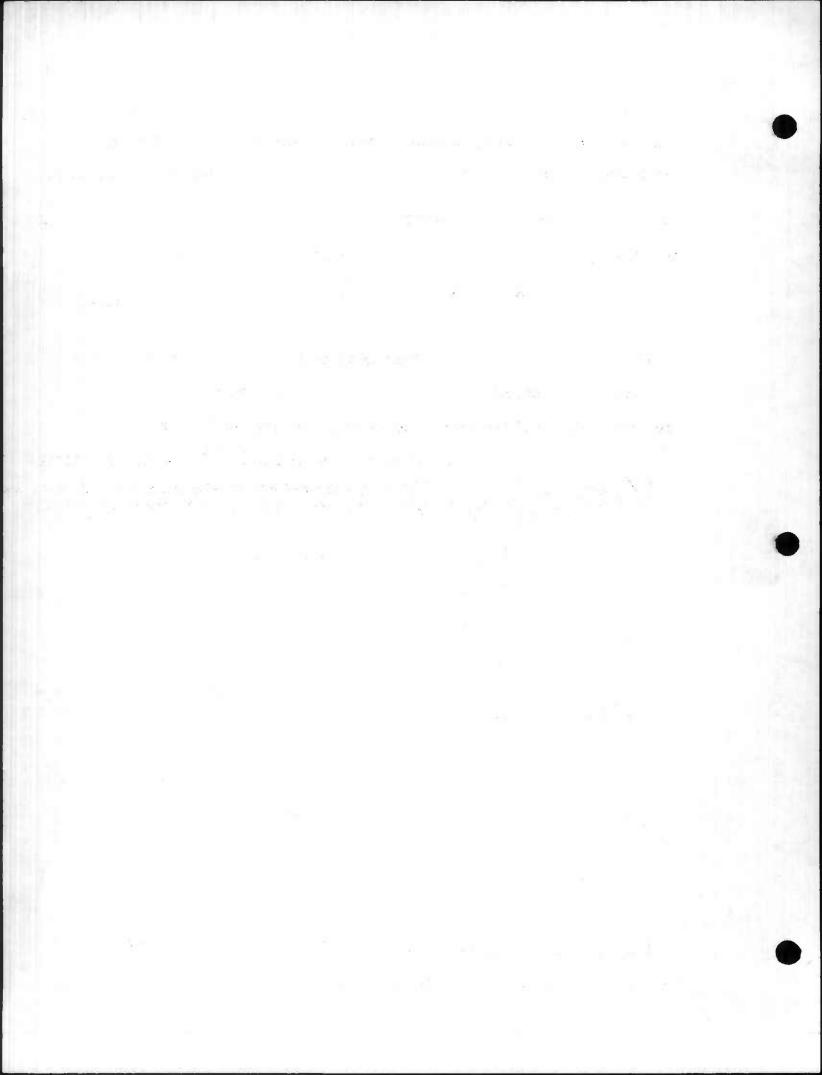




# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q

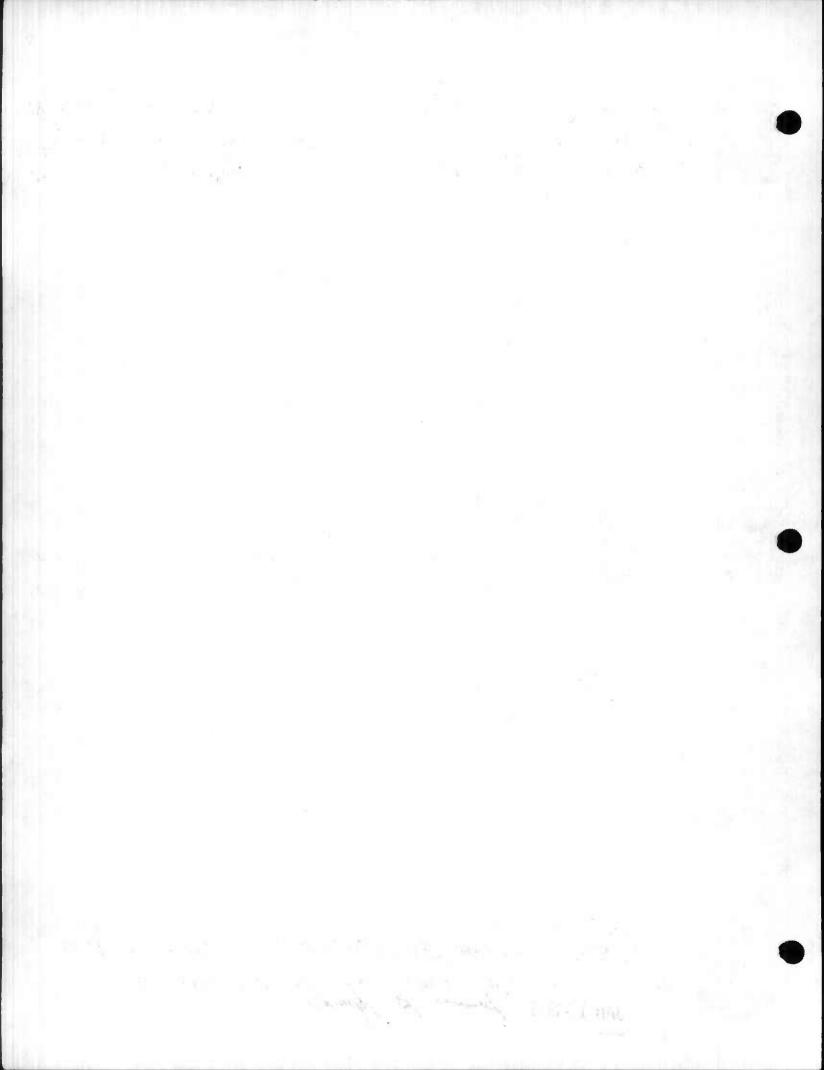
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month David E. Alpigini Jan, /Medical Jan. 11, 1999

4b. City, Town, or Location of Death 4c. County of Death 8:40 P.M. 4a. Facility Name (If not institution, give street end number) **Examiner** Genisis Elder Care/ Heritage Nursing Center **Baltimore** Dunda1k If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5. Social Security Number If Under 1 Year Months Days 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country) **Funeral** M 20 F Days Director 218-07-1816 83 Oct 9-1915 Pennsylvania Usual Residence of Deceden with the Maryland 10a. State an "natural", or items 23a or 28a-f show Medical Examiner multi be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Baltimore Dundalk 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 2404 Keyway U.S.A. 21222 death Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 □ No ir res, Give Year or Dates: 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Eiementary/Secondary (0-12) College (1-4or 5+) The Welder/Electrican Steel Company altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) . Peges 1 and 2 should be fill ment of Health and Mentel Hant: If item 27 is marked oth lury or other traumatic even Be Elmer Bruce Alpigini Ella Berry 19a. informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marrianne Alpigini/ Daughter 2404 Keyway, Dundalk, Md. 21222 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1-14-99 Burial 2 Cremation 3 Removal from State permit. Pege Depertment of important: If any injury or 4 Donation 5 Other (Specify) Sacred Heart of Jesus Cent. Balto., Md. 21222 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton-Dabrowski-Matthews Funeral Home, Inc 21134 Willow Spring Rd., Baltimore, Md. 21222
hat cause the death. To not enter the mode of dying, such as cardiac or respiratory arrest,
Approximate 23a. Pert . Enter the disease, of shock, or heart failure. List of Approximate interval Between Onset and Deeth **Physician** /Medical immediate Cause (Finai FAILURE disease or condition resulting in death) Examiner Physician/Medical Examiner DEHYDRATION The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Last buriel-trar TRACT INFECTION HRONIC URIMARY
Due to (or as a consequence of): Box 68760. the Se esn EMENTIA P.O. 1 Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate hes 1 Yes 2 No of Vital Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this in by the funeral 27. Manney of Death Certification: 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After Division 1 Neturai 5 Pending investigation deeth. 1 Tyes 2 No 2 Accident or Attend eter deeth Director: 6 Could not be determined 3 Sulcide 28e. Place of injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled is 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and menner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) why 2 Marller anuder 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1999 Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 00594

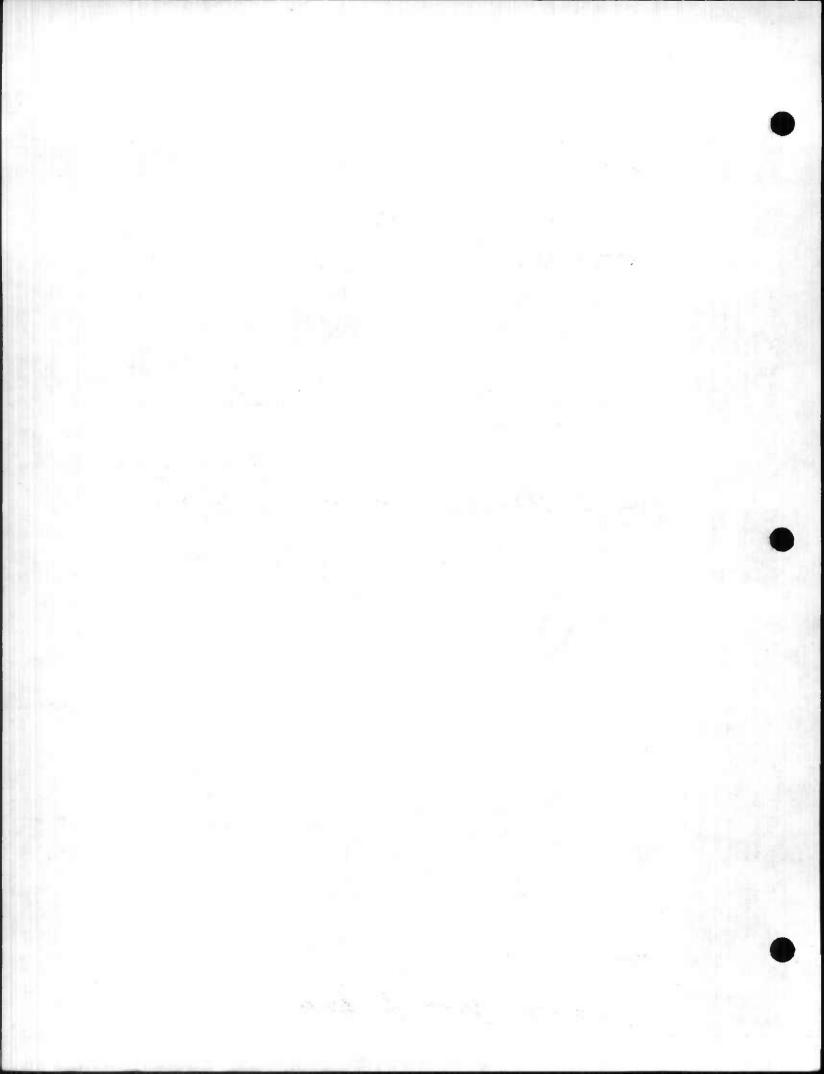
		1. Decedent's Na	me (First, Middle, La:	st)	A 11	Jerun	cate of	Dealli	2. Date of De	Reg. No.		3. Time of Death
Physic /Medi		5115	Sid .	M	411	ien			Month	Day	Y 299	1:35 AM
Exami		4a. Facility Name	(If not institution, give	e street and number)	1			4b. City, Town, or I	Location of Dear		y of Death	1
		Churc	h Nur	sing Len	ter			Balti.	more	Ba	Himux	e City
。Funeral Director		5. Social Security 240 3 Usual Residence	27817 1	ex 7. Age	173		Under 1 Year onths Days	If Undar 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)	9. Birthple Count N A	ace (Stata or Fereign ry)
yland now		10a. Stata	10b. County		10c. City, To	own or Locatio	n				10	d. Inside City Limits
ter death with the Marylan Items 23e or 28s-f show Iner must be notified at	ctor	MD	NA		Balt	timore						XQYas 2□No
or 2	Director	10e. Street and N				10	of. Zip Coda			10g. Citizan of	What Count	ry?
23	eral		orth Broa		II O		1231			USA		
9 9	by Funeral	1 1 1 1 1 1 1 1 1 1 1 1 1	rried 2 Married 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yas 2 ☑ N If Yes, Giva Yaar or Dates:			becedent of F , specify Cub as 2 No	dispanic Origin? (S an, Mexican, Puert Specify:	pecity Yes or Ne o Rican, atc.)	Specia	ce - Amarice ack, White, e	tc.
hin 72 hours in "natural", Medical Ex	eted	(So	15. Decedent's Ed	lucation da completed)	16	Sa. Decedent's	Usuel Occup	pation	kina	16b. Kind of E	Business/Inde	ustry
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Mer Mer	To		Name/Relationship (7		4	Oh Malling Ad	Ideas (Carret	Geneva		Hin		20702
2000		Johnn	J. Done	elson								code) 20783 ville, MD
		20a. Method of Di			20b. Piace	of Disposition tery, cremator			Date	20c. Location		
Peges nent of int: If its iry or o			2 ☐ Cremation 3 ☐ 5 ☐ Other (Specific					'l Ceml	01-15	-99 E	altin	more, MD
permit. Peges 1 ar Depertment of Hea Important: If item 2 any Injury or other		21. Signature of F	Funeral Sarvica Ucen	GALL	1AX	22. Nar WM .	ne and Addre	es of Facility Ch FH 1	101 E.	North	Ave	nue <sub>21202</sub>
		23a. Parti. Enter	the diseasa, of comp	plications thet caused one cause on each lin	the death. D							Approximate Interval Between
Physician /Medical		Immediate Cause										Interval Between Onsat and Death
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death e atte ed for	sicia	Part II, Other sign	ificant conditions co	entributing to death bu	t not resulting	in the underly	ring cause giv	en in Part I	23h. Did	tobacco use co	ontribute to	the cause of death?
s that the death cert med by the attendin e detached for use	by Physician/N			The state of the s	t not resulting	, in the underly	mig oduse giv	on mr aits.		Yes 2□ No	3 Probe	11
The law requires thet the death cer ate hes been signed by the attendir page 2 shouid be detached for use	Completed t									an eutopsy ormed?	avai	e eutopsy findings labla prior to pietion of cause eath?
	Com								1 🗆	Yes 2 No	1 🗆	Yes 2)(No
ysician: The lav is certificate hes director, page 2	Be	25. Was case refe examiner?						28. Piace of Dea	th (Check only	one)		
Physician: r this certific ral director,	2	1 Yes 27	1140	Hospital: 1 ☐ Inpatier			DOA Oth	4 Nursing H		dence 6 □Ott		
After funer	tlon	1 X Naturai	5 Pending Investigation	28a. Data of Injury (Month, Day	Year) 28b	Tima of Injury M	28c. Injur	yat k? Yes 2 □ No	28d. Describe	how injury occur	rred	
f or Attending efter death. Director: Afte d in by the fune	Certification:	2 ☐ Accident 3 ☐ Suicida	6 ☐ Could not be		ry - At home.			163 2 1140	28f. Location (	Street and Numi	ber or Rural	Routa Number.
s effer 1 Direct of in by	ert	4  Homicide	determined	building, etc.	(Specify)		,		City or To			
To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral	edical C	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	rsician: To the best of iner: On the basis of and manner stat	examination e	ge, deeth occu and/or Investig	rred at the tin ation, in my o	ne, date and place, pinion, death occur	end due to the red et tha time,	cause(s) and m date and plece,	enner as sta end due to t	ted. he cause(s)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** JAnua 13 1999 ion of Deeth 4c. County of Deeth 0345 SANICE BLUNT /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) **Examiner** of MARYLAND HOSPITAL BACtimore If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey, Year) If Under 1 Yeer Birthplece (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** 1□M 200 F Va 89 220-24-2326 -30-1909 **Director** Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mentel Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumstic event, the Medical Examinet must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10e. State Randallstown 1 Yes 2 No Baltimore Director Ma 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3721 21133 Road Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
if Yes, Give 7
Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11. Marital Stetus Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Post Hice 0 Elementary/Secondary (0-12) College (1-4or 5+) Nurse 1241 grade 4 years 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be ree Hall Hatcher 19b. Malling Address (Street and Number or Rurel Royte Number, City or Town, Stete, Zip Code) 211 33 19<sub>Pa</sub> Informent's Neme/Relationship (Type, Print) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Run Koad Kandallstown, md Niece 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Long Island National 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility . West Dalto, Md ZIZIS 300 Wabash guenue relle Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or need tailure. List only one cause on each line. Approximete tntervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner ANEMIA The law requires that the death certificate be executed ing physicien end e as the buriel-trans Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Lest P.O. Box 68760. Due to (or es a consequence of) USB signed by the e 23b. Did tobacco use contribute to the cause of death? Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed? Completed hes he 2 s certificate he 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physicien: 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: Delinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 this 28c. Injury et Work? Manner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: After 1 Neturel 2 Accident 5 Pending investigation To the Hospital or Attending within 24 hours after death. ▶ To the Funeral Director: After completely filled in by the fun 1 Yes 2 🗆 No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated.

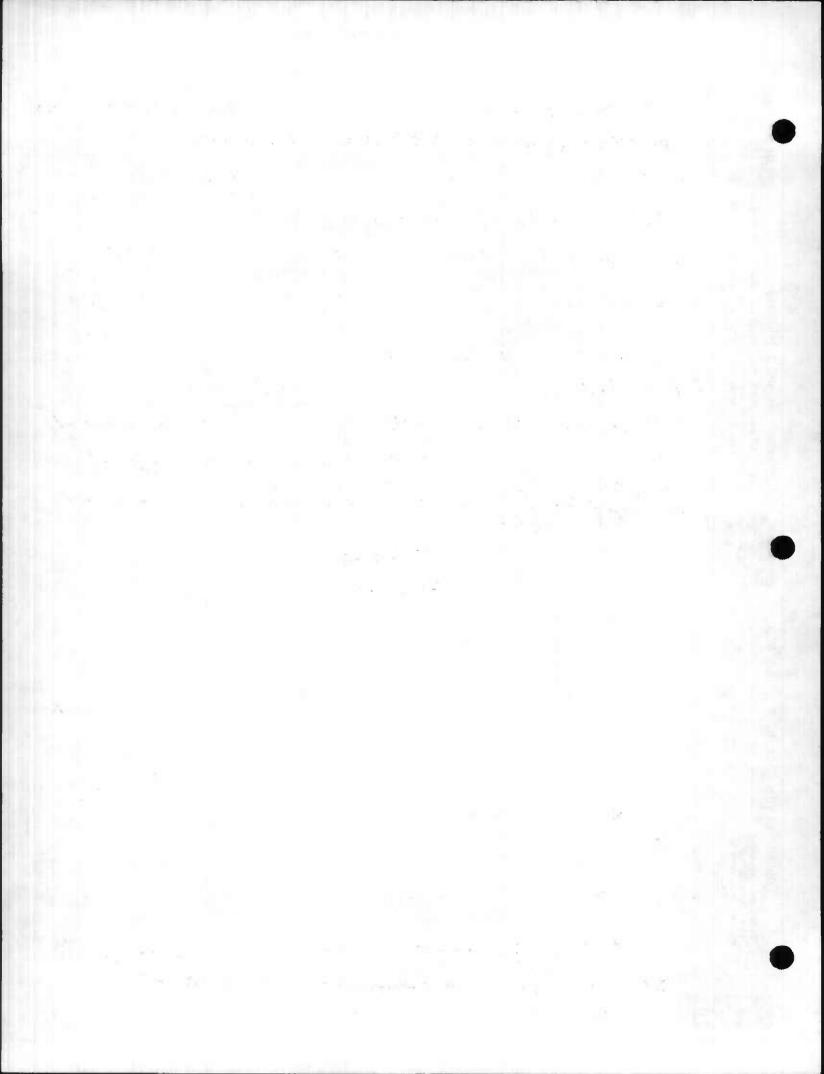
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Neme and eddress of p eted cause of deeth (Item 23e) (Type, Print) South Green St nsen 22

DHMH 16 Ray 6/95

State Registrar 31. Dete filed (Month, Day, Year)

JAN 1 5

32. Registrer's Signeture



certificate be execu Box 68760, Division of Vital Records, Hospital or Attending To the Hospital within 24 hours e

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

**Funeral** 

**Director** 

in end Mental hygiene. ? Is marked other than "natural", or fleme 23a or 28a-f show traumatic avent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if flem 27 is marked oth any linity or other traumatic avent pois.

**Physician** 

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altimore, Maryland 21215-0020

State Registrar

31. Date filed (Month, Day, Year) JAN 1 5 1999

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30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

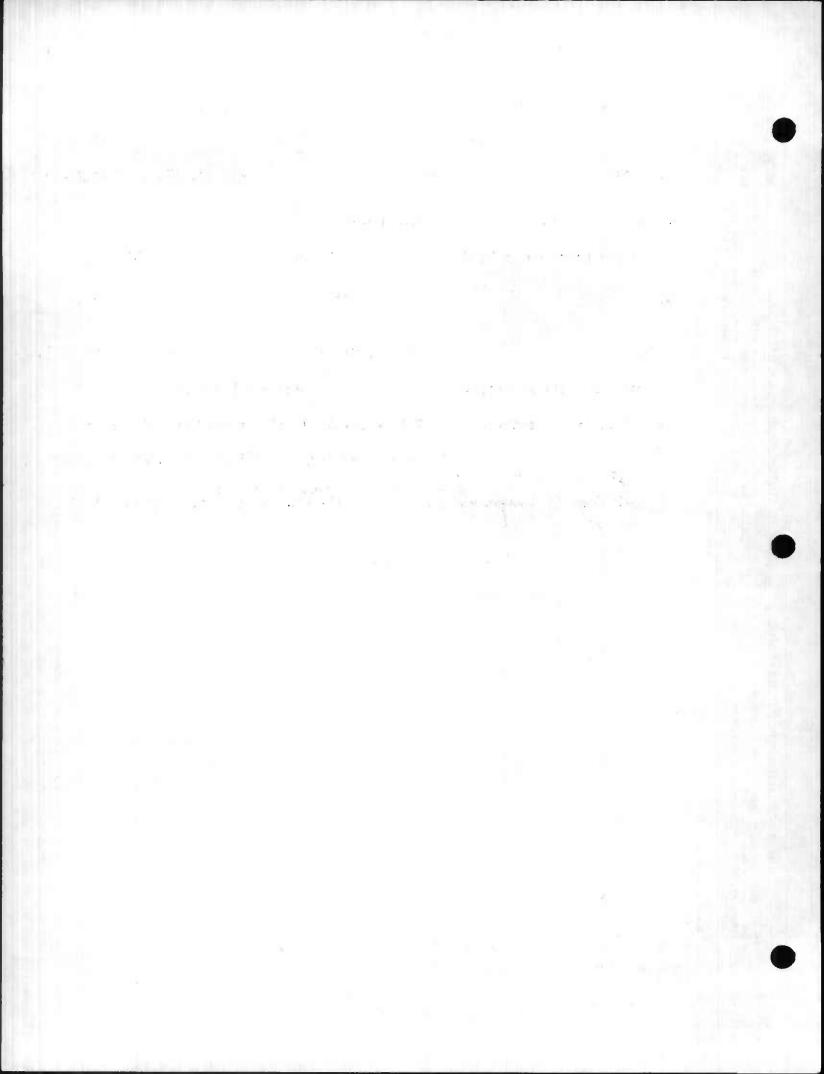
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21224



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month EVELYN M. BALDWIN 4b. City, Town, or Location of Death 4c. County of D 4a Facility Name (If not institution, give street and number) Franklin Square Baltimore enter If Under 1 Year ospital -osedale Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1 M X F 69 Maryland 212-38-4201 Aug. Usual Residence of Decedent 10a. State Maryland 10b. County. Baltimore 10c. City, Town or Location 10d. Inside City Limits Baltimore County-Towson 1 Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 USA 2 Waterway Ct. Apt. 1B 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Yes X No if Yes, Give Year or Dates; 1 Nevar Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) State of Md. Brd. of Super-Elementery/Secondary (0-12) College (1-4or 5+) N/A Administrative Clerk visors of Elections ll yrs. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Marie E. Lawson Charles O. Bauer 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1515 Providence Rd. Baltimore, Md. 21286 Mr. Thomas C. Baldwin (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Zion Church Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
Donation 5 Other (Specify) 1-16-1999 Baltimore, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lassahn Funeral Home lassar 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that initiated events resulting in death) Lasf Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ulmonaru 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury 1 TYes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a Cartifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) manner stated. 29b. Signature and fitte of certifier 29c. Licensa number 29d. Dafa signed (Month, Day, Year)

# 68760 Box ( P.O. Division of Vital Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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"natural", or hams 23a

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**Physician** 

/Medical Examiner

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Physician/Medical Examiner

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Medical Certification: To

Director

Funeral

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or Attending Physician:

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To the Rospital or Atta within 24 hours after de To the Funeral Directo completaly filled in by th

this

Director:

Registrar

**DHMH 16 Rev 6/95** 

9000 Franklin Square

30. Nama and address of person who completed cause of death (tem 23a) (Type, Finit)

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32. Registrar's Signature

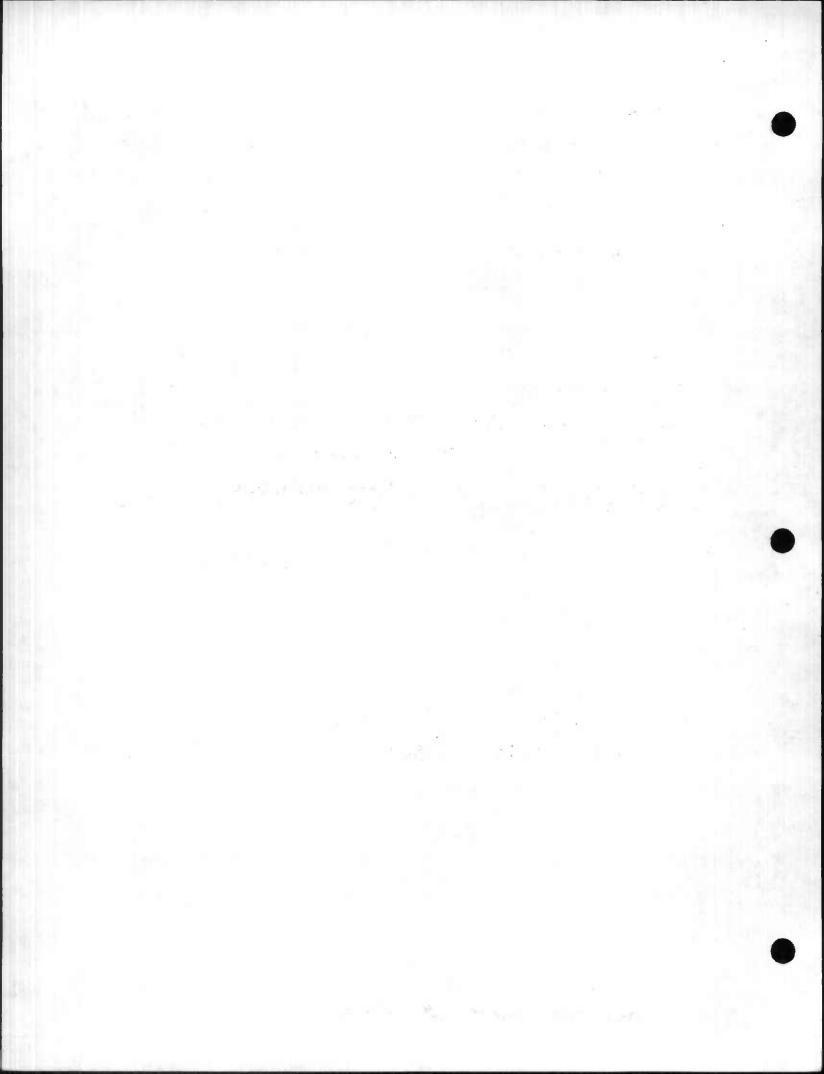
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5 1999

31. Date filed (Month, Day, Year)

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Baltimore, MD 2/237



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 0 5 9 9 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Jan. 13, ELEANOR MARJORIE BECKER 1999 12:02 a.m. 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death 410 David Court Bel Air Harford 8. Data of Birth (Month, Day, Year) NOV. 4, 1914 9. Birthpiace (Stata or Foraign Country) North Carolina If Under 24 Hrs Hours Min. 5. Social Security Number If Undar 1 Yaar 7. Age (In yrs. last birthday) Days 1 □ M 2 X F Months 84 240-44-7893 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 David Court 21015 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decadent Evar in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yes, Give Yaar or Datas: 14. Race - Amarican Indian, 11. Marital Status Biack, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry ementery/Secondary (0-12) Coilege (1-4or 5+) 12th grade Own Home Homemaker 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middla, Maiden Sumema) William Erastus Becker Mary Julia Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straet end Number or Rural Routa Number, City or Town, Stete, Zip Code) Bel Air, MD. 21015 Rena M. Johnson (Daughter) 410 David Court. 20b. Piace of Disposition (Name of camatary, crametory or other placa) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🕱 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Raleigh Mem. Park 11/16/99 Raleigh. North Carolina 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Servica Licensee 610 W. MacPhail Road, Bel Air, MD. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE IYEMR CONGESTIVE HUART disease or condition resulting in death) Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of causa of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Piece of Death (Check only ona) Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

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**Funeral** 

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7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Masical Examiner must be notified at

al Hygiene.

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permit. Pages 1 and 2 Department of Health e, Important: If item 27 ie any injury or other trat once.

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Baltimore.

Examiner Physician/Medical þ Completed Be 2 Certification:

attending physician end for use es the buriel-transit certificate be axecuted Box 68760. 98 980 dateched P.0. signed b of Vital Records, After this Division death. after death Director: /

that initiated events rasulting in daath) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yas 22 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 29e. Certifier 🔂 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and menner as stated 2 Medical Examiner: On the basis of exeminetion end/or Investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

24 hours

To the Hosp within 24 hos To the Fune completely fi

edical

31. Date filed (Month, Day, Yaar) JAN 15

29b. Signature and title of cartifier

HNOREN NOWAKOWSKI 32. Registrar's Signature Al paragraph

Andra Newalrows

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

125 N, MANN ST (SEZAM, MD20014 hoosen

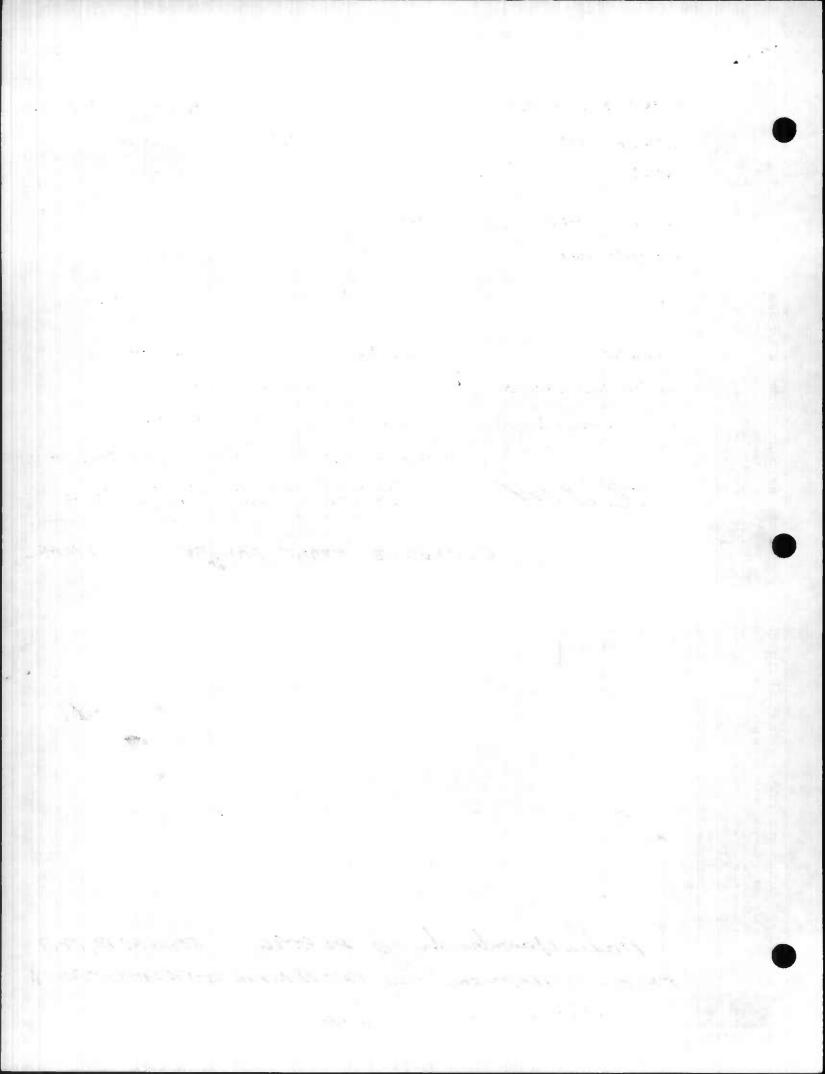
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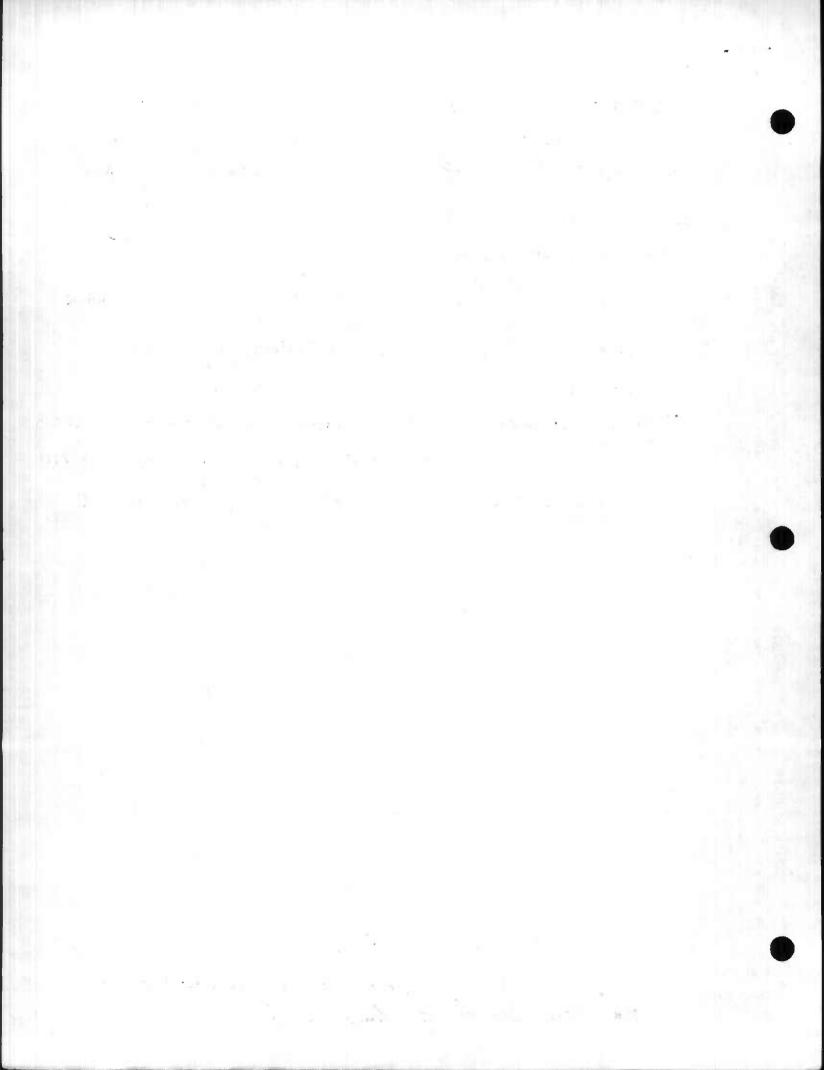
29d. Data signad (Month, Day, Year)

JANUARY 13, 1999



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Physician	1. Decedent's Name (First, Middle, Last,					2. Date of De			Time of Death
/Medical	WILLE JO	imes Bell				JANUAF			5:00 AM
Examiner				1	BALTIM	or Location of Deet	4c. County	of Death	
Funeral	JOHN HOPKINS HOS  5. Social Security Number 6. Secu			nder 1 Yeer	If Under 24 H	rs. 8. Dete of Bir	th	9. Birthplace	(State or Foreign
Director	416-70-6183	20 F 48	Yrs. Mont	hs Days	Hours Mi	in. (Month, Da	20, 1950	Country)	(State or Foreign
P .	Usual Residence of Decedent	40-0	Taum and another						
ahov			y, Town or Location						nside City Limits
with the Me to 28a-1 a be notified	Maryland N/A  10e. Street and Number		altimore	Zip Code			10g. Citizen of V		
3a or	2527 Garret	+ Avenue	1.0		218	100		S. A.	
5-0020 72 hours after death with the Meryland natural, or harm 23a or 28a-f ahow death Examinat must be notified at the by Furneral Director	11. Marital Status	12. Was Decedent Ever in U, Armed Forces?	S. 13. Was De			(Specify Yes or No erto Rican, etc.)		- American Ir	ndian,
or the star of T		1 ☑Yes 2 ☐ No	1 □ Ye	s 202 No	Specify:	erto racan, etc.)	Specify	k, White, etc.	
yiand 21215-0020 uid be filed within 72 hours at Mental thygiana. arked other than 'natural', or afte event, the Medical Exern TO Be Completed by F	3 Widowed 4 Divorced	Year or Detes: 1970 -	-75					ントイ	
1 21215-0 led within 72 ho hyglene. her then "nature it, the Medical.	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Decedent's L (Give kind of life, DO NO	work done	during most of w	vorking	16b. Kind of Bu	siness/industr	У
2121 d within plane.	Elementary/Secondery (0-12)	College (1-4or 5+)	AU	TO M	ECHAN	UIC	Au	to	
be filed to the filed worth by the filed by	17. Father's Name (First, Middle, Last)				18. Mother's N	leme (First, Middle	, Meiden Sumam	e)	
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프 교육원은	21. Signature of Funerel Service License		22. Name	and Addre	ss of Facility	Funeral	Carry	5 /4///	1, 190
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Physician /Medical Examiner		. Hypothermia	ras a consequence	ed wit	h Acut	e Ethanol	Intoxic	ton	
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ding ding tone	1 Neturel 5 Pending 26 Accident investigation	(Month, Day Year)	Injury 4524 <sup>M</sup>	28c. Injur	k? Yes 2 KNo		mental ex		
DIVISION Of VITAI RECO To the Hospital or Attending Physiolan: The law re within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh Medical Certification: To Be Complete	3 Suicide 6 Could not be determined	28e. Plece of Injury - At ho building, etc. (Specify	me, farm, street, fed			City or To	Street and Numb	, RIL OL	ute Number, erwool A
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thin 24 thin 24 the F	29b. Signatum and title of certifier	end manner steted.		29c. Licens		1	29d. Date signed		
<b>₽₹₽</b> 8	Salamina and title of certifier	111							
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)	Dennis C	hute mi		Stre	et. Bal	timore, N	Maryland	21201	
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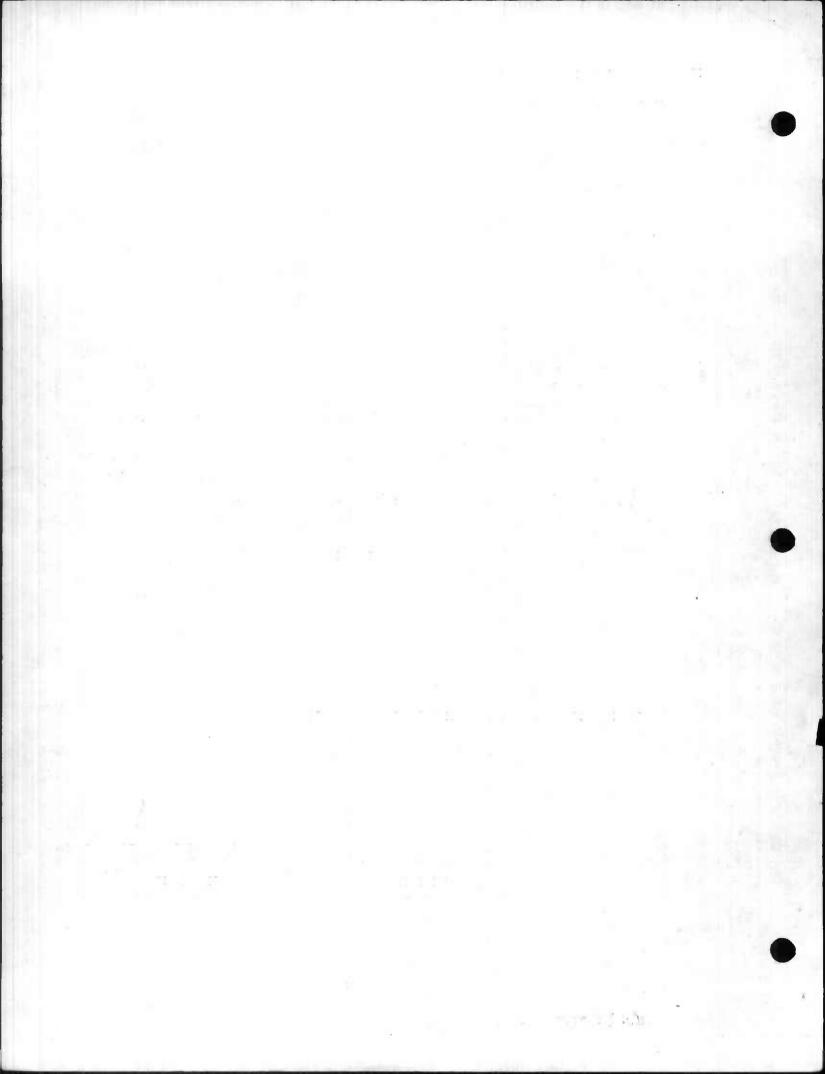


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James Crawfoi	TEMS: #23 PART I, II,	State of Man	NED G768 Cel	tificate of	Death		Reg. No.	00	001
	1. Decedent's Name (First, Middle, L	ast)				2. Data of Dea	Dev	Year 3	3. Time of Death
Physician /Medical	James Samuel C	rawford Jr.				January	7 05, 1.9	999 1	2:24 P.M
Examiner	4e Facility Name (If not institution, g	ive street and number)			4b. City, Town, or I	Location of Death	4c. County	of Death	
DEL CONTROL	2204 Callow Aver 5. Social Security Number 6.		n yrs. last birthday)	If Under 1 Year	Baltim If Under 24 Hrs.	9 Date of Bid	N,		e (Stete or Foreign
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pu & =	Usual Residence of Decedent  10a. Stete 10b. County	10	Oc. City, Town or Lo	cation				tOd.	Inside City Limits
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vith the Mar t or 28a-f at be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country	7
th with	33 South Hilto	n Street			21229	114		USA	
urs after dee	11. Meritel Status  1 Never Married 2 Married  3 Widowed 4 M Divorced	12. Wes Decedent Eve Armed Forces? 1 Yes 2 ANo If Yes, Give Year or Detes:		Was Decedent of I I Yes, specify Cub	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Bla	ce - American I ck, White, etc. y: Black	
1 21215-002 led within 72 hours lygiene. The treatment, it, the treatment Completed by	15. Decedent's 8 (Specify only highest g		(Give	lent's Usuel Occup	during most of wor	king	16b. Kind of B	usiness/Indust	lry
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timore, Maryland 212  . Pages 1 and 2 should be filed with unent of Health and Mental Hygiens. fant: if Nem 27 is marked other than jury or other traumatic event, the state  To Be Comp	James S. Crawfo					s Neal	Waldon Dame.		
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Saltimore, semit. Pages 1 ar beard of Heal moorant: If them any Injury or other mea.	20a. Method of Disposition	La Colonia de la		netory or other ple		Dete	20c. Location		
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Baltimore, N permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to page.	21. Signeture of Funeral Service Lio	2 Chal			er Avenue				21215
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8760, cate be executed physician and the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	e to (or as e consequence to (or es a consequence)	•					
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Physic Physic oral direction of To	Yes 2 No 27. Manner of Death	1 ☐ Inpatient	2 ER/Outpatien	( 3LI DON	4 I Nursing H	ome 5 A Resident			2110.50
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of the	Alten	A 1/10	12 11	0.0	C.M.E.		January	7 06. 1	999
	30. Name and address of person who	completed cause of death	(Henv 23a) (Type, I					- 47 1	
	Stephen S.	Radentz,		ll Penn S	Street, B	altimore	e, Maryl	land 21	.201
State	31. Dete filed (Month, Day, Year)	32. Registrar's	Signeture						

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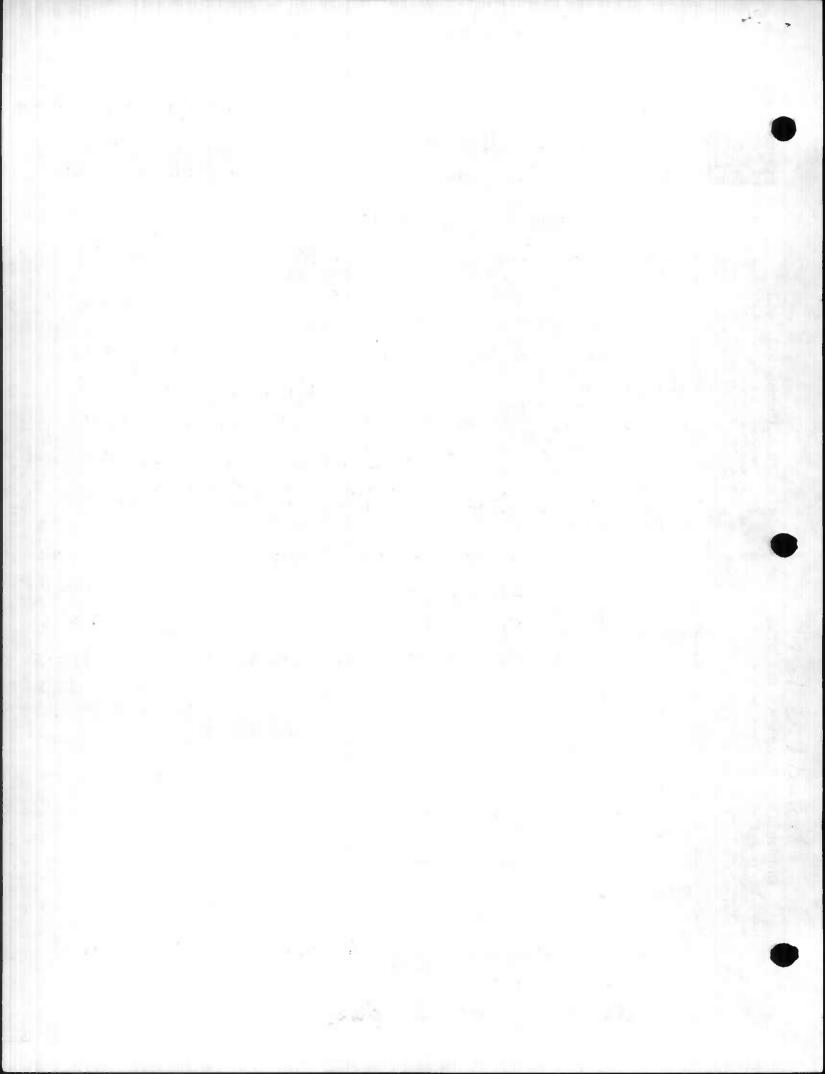
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Deeth 3. Time of Deeth Month Day JANUALIY **Physician** 5:10 Am 1999 COLES KONALD 0. /Medical 4b. City, Town, or Location of Death 4e Facility Nema (If not institution, giva streat end number) 4c. County of Death BALTIMORE NA MEMORIAL OSPITAL UNION If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthplece (State or Foreign Country)

A 5. Sociel Security Number 6. Sax Aga (In yrs. lest birthday) **Funeral** Days Months 1 M 2 F 114.42.0973 Yrs. Director Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene, int: If Item 27 is marked other than "natural", or items 23s or 28s-f show Lry or other traumetic event, if a Medical Examinar must be notified at 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits BAUTMORE 1 PYes 2 No NA Funeral Director MD 10g. Citizen of Whet Country? 10e Street and Number 10f. Zip Code 21214 RIVE 12. Was Decedant Ever in U,S. Armed Forces?
1 ☑ Yas 2 ☐ No If Yes, Give 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK à 3 Widowed 4 Divorced Yaar or Dates Completed 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest greda complated) College (1-4or 5+) Elementery/Secondary (0-12) t000 SERVICE 12 TH GRADE YR. OST 17, Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Be COLES HARVEY 2 ATHERINE JONES 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 115TH DRIVE 15530 MOTHER ATHERINE JONES SAMAICA, NY 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 M Buriel 2 Cremetion 3 Removal from State Department of Important: If any injury or once. BALTO. MD 4 ☐ Donetion 5 ☐ Other (Specify) 4RBUTUS CEMETERY 21. Signeture of Funerel Service Licansee 22. Neme end Address of Facility 23e. Pent. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** /Medical Immediate Cause (Final years disease or condition resulting in deeth) AND Examiner Due to (or es a consequence of): Physician/Medical Examiner =Sophageal Vances Vear ettending physician and for use es the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Due to (or es a consequence of) ears Due to (or es e consequenca of): Ronald Coles END Renal Disease, on Hemodialysis yours signed by the eld be deteched for Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Itepatitis Completed by 24b. Were eutopsy findings aveilebla prior to 24e. Wes en eutopsy performed? complation of causa of deeth? realificate has b irector, page 2 s AnemiA 2 No 1 Yes 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 27 Manner of Deeth 28a. Dete of Injury (Month, Dey Yaar) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident I hours efter death uneral Director: in 24 hours the Funeral Director In filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

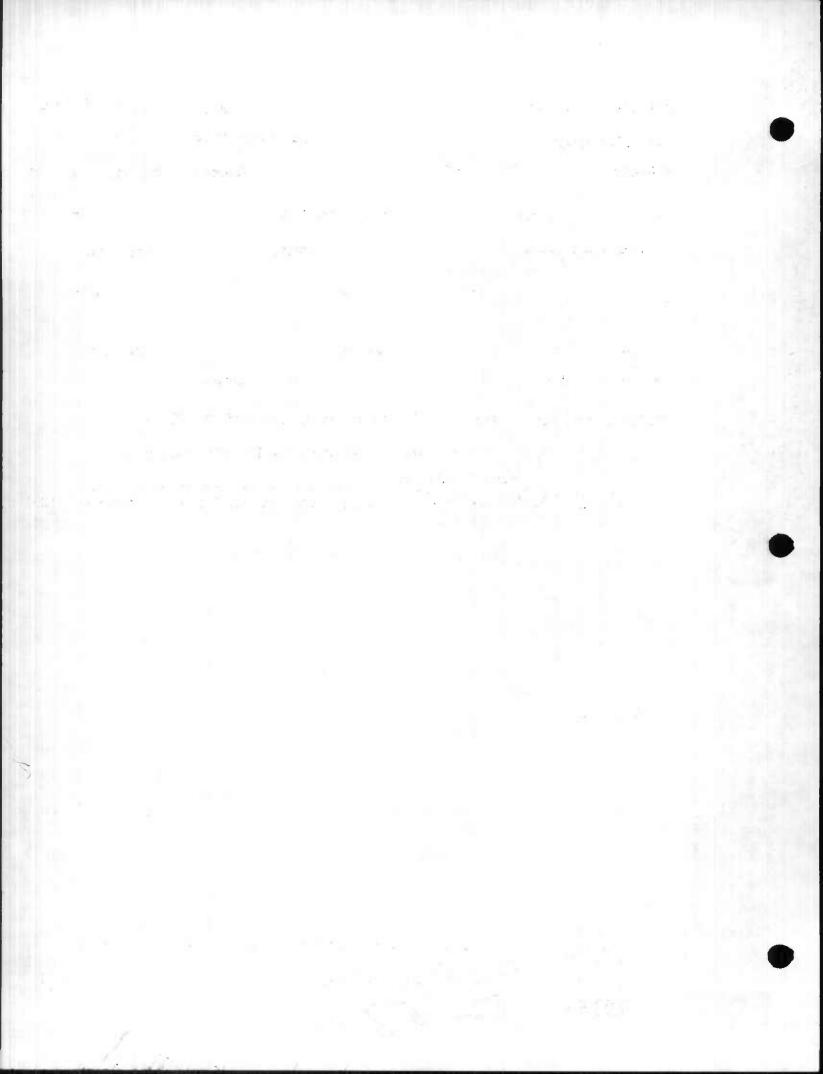
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medicai 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. Licansa number 29d. Dete signed (Month, Dey, Year) 29b. Signatura and titla of certifier Susan Jensen, M.D. January 14, 1999 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 201 E University Pkwy, Baltimore MD 21218 SUSAN JENSEN, M.D. 32 Registrer's Signeture 31. Date filed (Month, Day, Year) 1999 Registrar



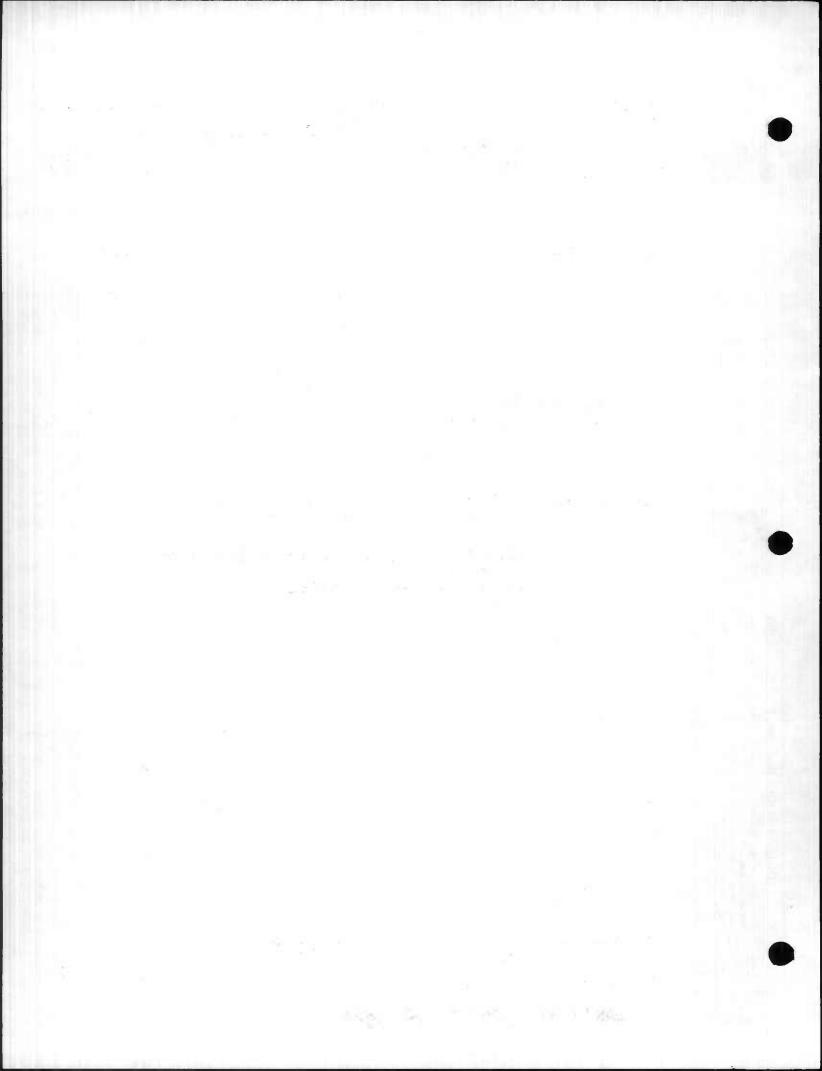
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 2. Date of Death 1. Decedent's Nema (First, Middle, Last) 3. Time of Death Day Year Month **Physician** Mary Elizabeth Curry 9:20pm 8, 1995 4c. County of Death Jan. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore City N/A Gilchrist Hospice If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Birthplaca (Steta or Foreign Country) **Funeral** Days 1 M 2/2 F 96 233-72-2931 Director December 26, 1902 Higginsville, MO Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. inside City Limits Yes 2□No WV Cabell Barboursville Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1109 Main Street 25504 United States Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 3 ON If Yes, Give Year or Dates: 14. Race - Amarican Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Black, White, etc. 1 Naver Married 2 Married 1 ☐ Yes 25No Specify: Specify: White þ ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast greda completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 2+ 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be 8 Lytton Lee Lake Mamie Barger 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health. 705 Keats Road, Richmond VA 23229 William Curry, M.D. / Son 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ☐ Burlat 2 ☐ Cremation 3 ☐ Ramoval from State Ridoelawn Memorial Park, Jan. 13, 1999 Huntington, W 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr., 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest,

Approximate Approximate Interval Between Onset and Death **Physician** tailure Immediate Ceuse (Finat disease or condition resulting in death) acute respiratory
Due to (or as a consequence ot): /Medicai Examiner Examiner acute Onesmonia death certificate be axecuted physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last Due to (or as consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): for use as 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown main stem stroke Division of Vital Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Was an autopsy parformed? Completed has ils certificate ha 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ht Spice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To 1 Yes 2 No sinis 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Death 28c. Injury at Work? 28b. Time of Certification: or Attending 1 MNatural 5 Pending Investigation 1 ☐ Yas 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 ☐ Suicida 28f. Location (Straat end Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. edical 29c. License number 29b. Signeture and title of certifie 30. Name and eddress of person who completed cause of death (Keyn 23a) (Type, Print) Charles St. Balto, Md 2/208 16701 SMC 32. Registrar's Signature 31. Date filed-Year State 5 1999 Registrar **DHMH 16 Rev 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month **Physician** 5:00 AM Vatti /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number Examiner 5 M Dr 181 If Under 24 Hrs. If Under 1 Year Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 251-56-035 1 M 2 K 3 Yrs Director 3 Usual Residenca of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If flem 27 is marked other than "natural", or frems 23a or 28a-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examinar must be notified at 1 Vas 2 □ No NA Directo 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21217 Walbrook Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yea, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1□ Yes 2D No Baltimore, Maryland 21215-0020 Specify. Blank Specify: p 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Bustness/Industry Elementary/Secondary (0-12) College (1-4or 5+) aunda esser 1 th grade NA 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Johnny da -lowers 2 19a Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2/2/7 Towers Walbrook Avenue Dalto, Md Dernie Daughter 8/2 20b. Placa of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place, Burlal 2 Cremation 3 Removal from State = 8 permit. Page Department of Centery Star 4 □ Donation 5 □ Other (Specify) 21. Signature of Funaral Service Licensee 22. Name and Address of Facility · Wesi 300 Wabash Da Ito Md OA ad Approximate Intervat Between Onsat and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed attending physician and for use as the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown py 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 s 21000 1 Yes 2 No 1 Yes certificate Hospital or Attending Physician: 25. Was case rafarred to medical examiner?
1 Yes 2 No director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) Certification: To 1 Inpatient After this funeral 27. Manne of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturat 5 Pending investigation Injury death. 1 🗌 Yes 2 No 2 Accident aftar deat Director: 3 Suicide 6 Could not be 28a. Placa of injury - At home, farm, atreet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Piours 1 Striffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier edica and manner stated. To the Within 2 To the 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) Boateng 4126 31. Dete filed (Month, Day, 32. Registrar's Signature State JAN 1 5 1999 Registrar



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decement's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Deeth about oslick-199 gar JANUARY 7ey 8:28p 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) 67 Yrs. 9. Birthplece (State or Foreign Country) New Jersey 5. Social Security Number Deys 153 24 1830 Hours X⊠M 2□ F May 1, 1931 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Crofton Anne Arundel 1 ☐ Yes 2KHNo Maryland 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 21114 1728 Trent Street 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 ☑ Yas 2 ☐ No If Yes, Give 56-58 Year or Detes: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Educator University 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Robert Coslick Wilma Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Carol Sands 1728 Trent Street Crofton Maryland 21114 Fiancee 20b. Place of Disposition (Name of cametary, cremetory or other place) Jan. 15, Darg 99 20c. Location - City or Town, State 20a. Method of Disposition TEBurial 2 Cremetion 3 Removal from Steta 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Crownsville Maryland 22. Name end Address of Fecility Robert E. Evans Funeral Home, Inc. 21. Signature of Funeral Service Licenses 16000 Annapolis Rd. Bowie Maryland 20715 Approximate Interval Batwean Onset end Death 23a. Patr1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. CPS15 Immediata Causa (Final disease or condition resulting in death) Due to (or as e consequence of): BOLUEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Potension 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manyler of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No

Examiner The law requires that the death certificate be executed Box 68760. Physician/Medical the th 680 signed by the a d be detached t P.O. Records, py Completed of Vital or Attending Physicien: Be Certification: To this **Juneral** Division

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Department of Important: If Is any injury or o

Physician /Medical

Examiner

altimore, Maryland 21215-0020

To the Hospital Within 24 hours To the Funeral I

**DHMH 16 Rev 6/95** 

State Registrar

Medical

ICHERS 31. Data filed (Month, Day, Year) JAN 15

29b. Signature and title of certifier

2 Accident

3 Suicide

29a. Certifier (Check only

4 ☐ Homicide

6 ☐ Could not be

32. Registrar's Signeture 1999

600 NORTH

and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To tha best of my knowledge, deeth occurred at tha time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to the cause(s) and manner steted.

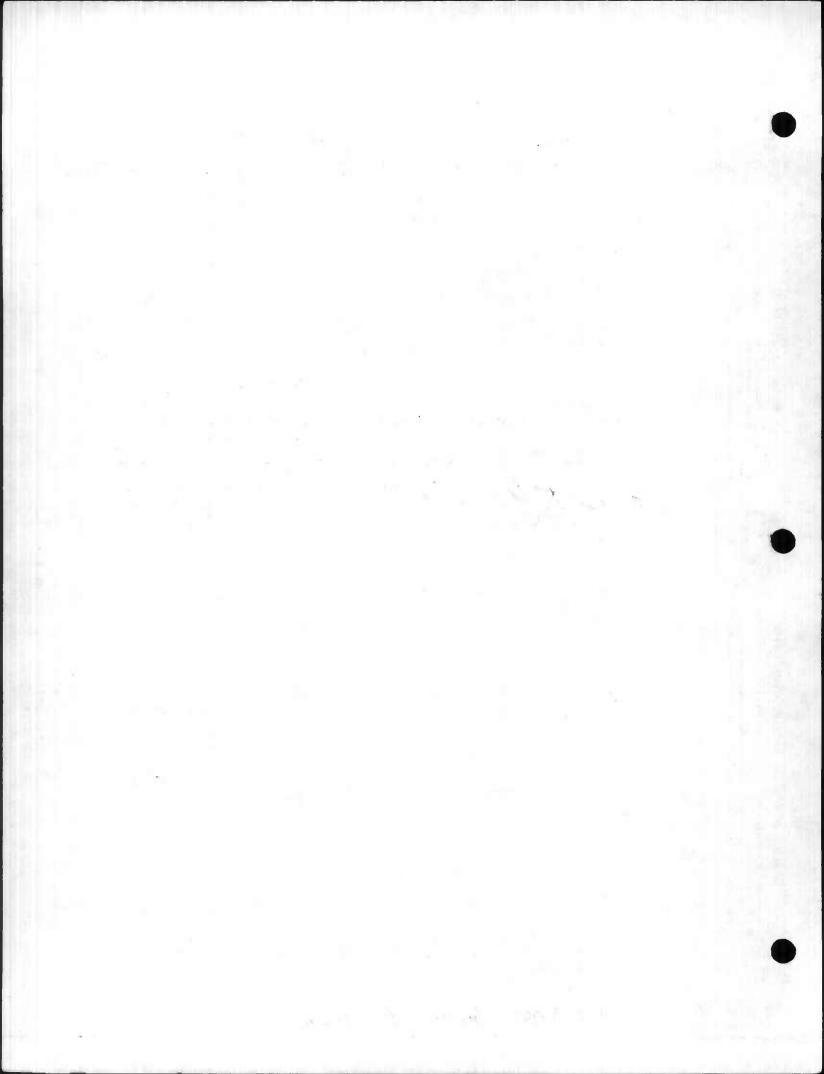
29c. License number

-000

28f. Location (Street end Number or Rurel Route Number, City or Town, Stata)

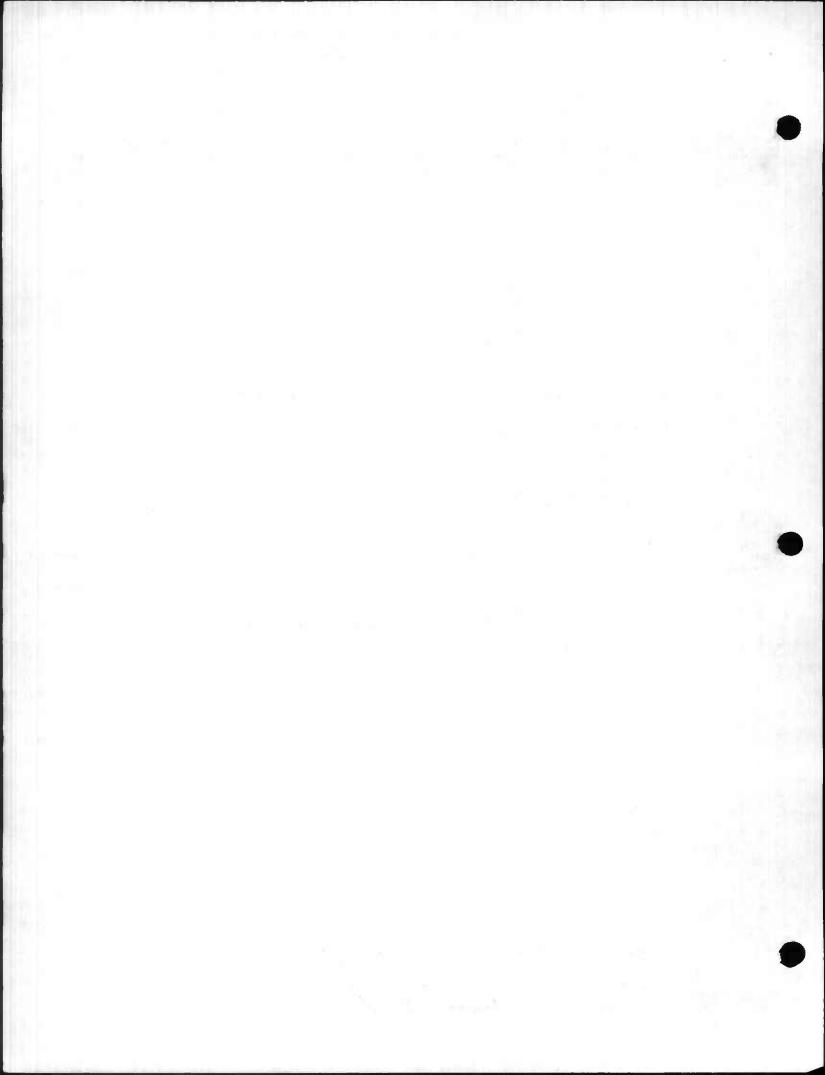
29d. Dete signed (Month, Dey, Year)

28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 0 6 6 6

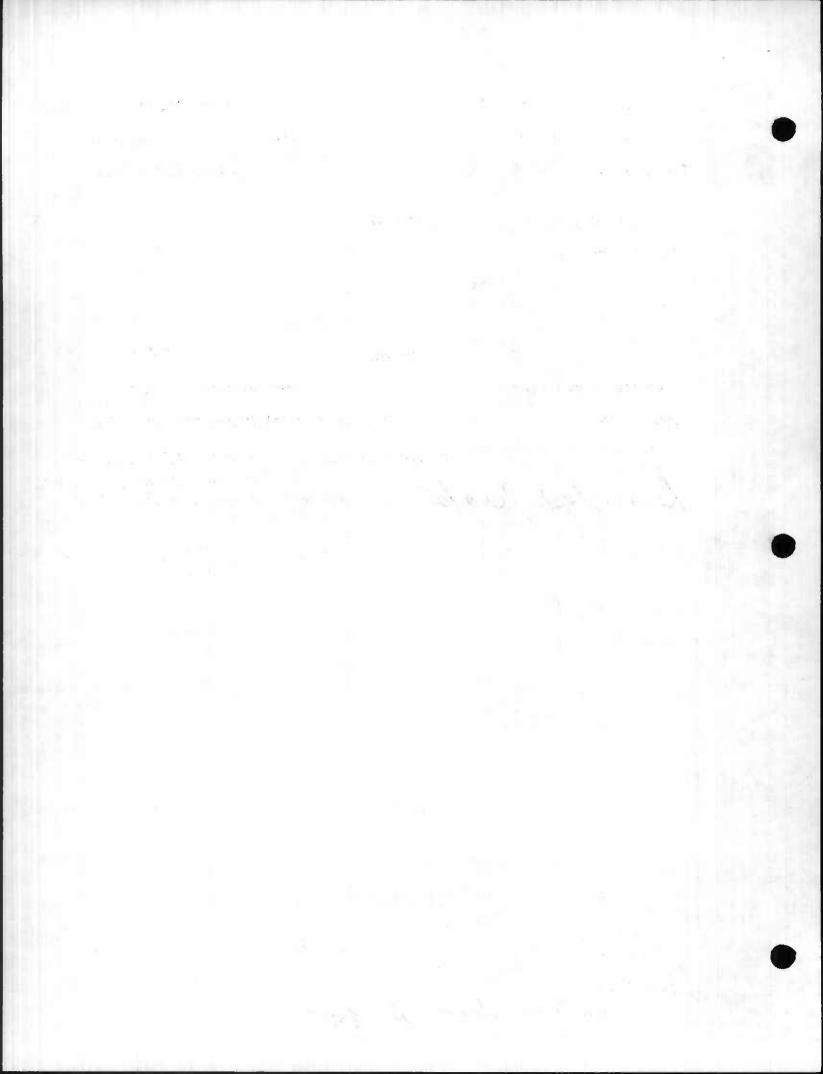
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ter death with the Manylan frams 23a or 28a-f show	Director	10e. Street end Number	A .	ba	1timore C:	ıty	T	10g. Citizen of Wh	net Country?
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南る日	by Funeral	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2  No If Yes, Give Yeer or Detes:		3. Was Decedent of if Yes, specify Cub 1 ☐ Yes 2 ☒ No		Rican, etc.)	Black,	White, etc.
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f Heelth tem 27 other to		Kathryn M. Connor	M.D. (Dghtr	) 111	Hamlet Hi	ill Road,	#1106.	Baltimor	e. Maryland 2 ity or Town, State
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death **Physician** MADELINE COOPER COX January 14,1999 5:10AM /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Gilchrist Center Towson Baltimore If Under 24 Hrs. Number 24 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M AXXF 215-42-7330 89 Yrs. Maryland Director Usual Residence of Decedent d 2 should be filed within 72 hours efter death with the Meryland th and Mantal Hygiene.
7 Is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Medical Evantmer must be nortifed. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 Dunkirk Road 21212 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Maritel Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Baltimore, Maryland 21215-0020 White þ XX Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) George Henry Cooper Mary Elizabeth Penning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Ia m any Injury or other traun John C Cox Son 717 Dunkirk Road Baltimore, Maryland 21212 20a. Method of Disposition

1 XVBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Parkwood Cemetery 1/18/99 Baltimore, Maryland 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Intervel Between Onset end Death Physician a. Chronic Lymphocyticles Kemia, prolymphocytic Immediate Cause (Final disease or condition resulting in death) /Medical Zweek Examiner Examiner physicien end s the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that the death certificate be Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 89 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 (No 3 Probably 4 Unknown multi-induct dementin þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed hes certificate her 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Tospice 10 1 Yes 2 No this 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) Certification: 5 Pending investigation After 1 Netural 1 Yes 2 No 2 Accident Director: / 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours efter To the Funeral Direc completely filled in b 0 12 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the Within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeturn and the of certifier mo 30. Name and address of person who completed cause of deeth (Term 23a) (Type, Print) Charles St. Balts. and 2120x JAN 1 5 1999 32. Registrar's Signeture State Registrar **DHMH 16 Rev 6/95** 

nadeline



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** Patricia Colegrove 12 1999 January 3:13 am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner #6 Athenry Court, #201 Timonium Baltimore If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 6 Sax 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Deys Hours Months 1□M 2√F Yrs 52 218-48-3503 Director August 11,1946 Maryland Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or frama 23a or 28a-f ahov Tra Medical Examiner must be notified at 1√ Yes 2 No MD Anne Arundel Annapolis Director 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 11 Williams Drive 21401 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 end 2 should be filed within 72 hours eiter nent of Health end Mental Hygiene. and If it it is not 7 le marked other than "natural", or its rry or other traumatic event, the Medical Examine rry or other traumatic event, the Medical Examine. 1 Never Merried 2 X Married ☐ Yes 2 f Yes, Give 20 No 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Vincent J. Naddeo Charlotte Nizer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health el Important: If Item 27 le any Injury or other trau Peter Lynn Colegrove-Husband 11 Williams Drive, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 N Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Holy Redeemer Cemetery 01/15 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Name egd Address of Fecility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licen 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Batween Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as e consequence of) Examiner and I-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequença of). physician a s the buriel-Physician/Medical Due to (or as e consequence of) 98 esn 23b. Did tobacco use contributa to the cause of death? ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Nos 2 No 3 Probably 4 Unknown signed l þ been sig 24e. Wes en eutopsy performed? 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed certificate hes l irector, pege 2 s 20 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No director, Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Mother's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 10 2 funeral 27. Manner of Death Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury et Work? Certification: 5 Pending investigation Neturel 1 ☐ Yes 2 ☐ No n 24 hours efter deeth.

Detely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 T Homicide edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end manner es stated.
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the ceuse(s) and menner steted. To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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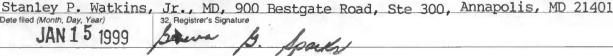
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Division of Vital Records, P.O. Box 68760,

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State Registrar

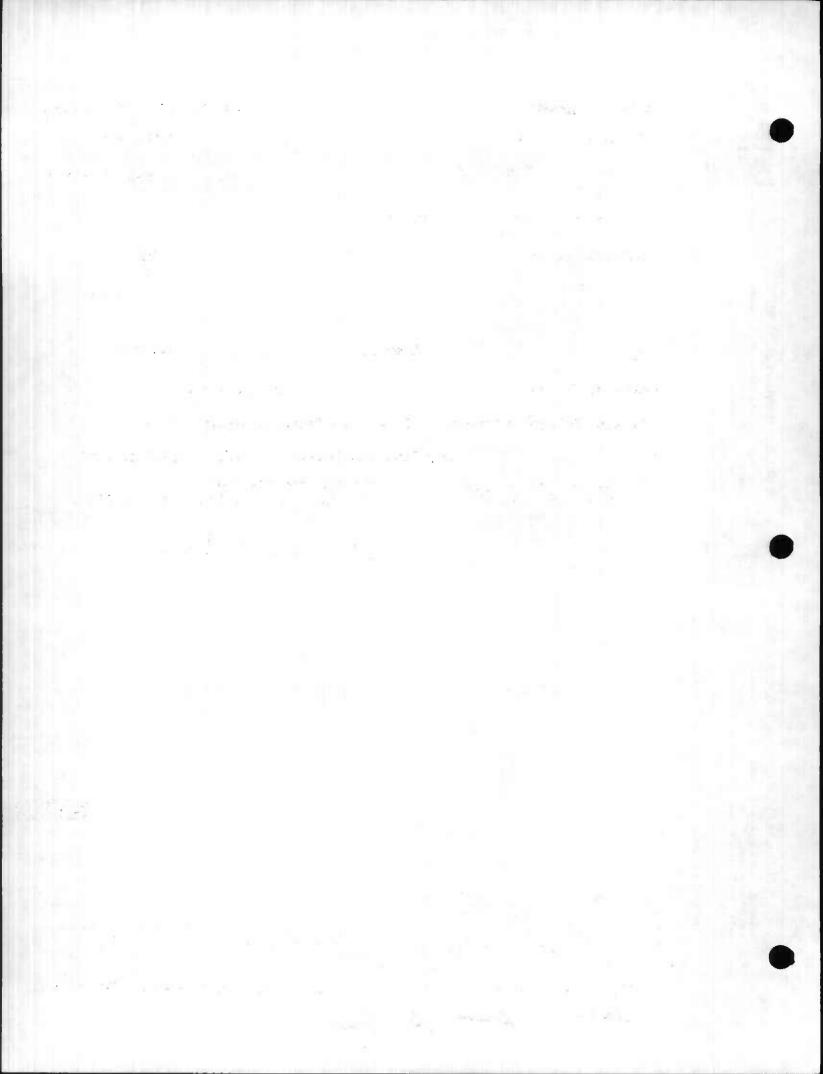
31. Dete filed (Month, Day, Year) JAN 1 5 1999



39 Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

**DHMH 16 Rev 6/95** 

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey 95KM **Physician** 1999 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not Institution, give street and number) /Medical Examiner Center Baltimore NA Johns Hopkins henatics If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 03-17-13 Birthplece (State or Foreign Country)
 GA If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthdey) 6. Sex Deys M 2DF Months 85 Yrs. 254-14-9813 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d, fnside City Limits MD NA Baltimore 1 Yes 2 No Directo 10e, Street end Number 10f. Zip Code 10g. Citizen of What Country? 524 North Decker Avenue 21214 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 □ Never Merried 2 □ Merried 1 Ves 2X No Specify Specify: Black by 3 □ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Flementery/Secondery (0-12) College (1-4or 5+) various trades Laborer 4th Grade 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Eva Dawson Charlie Dawson 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21213 19e. Informent's Name/Relationship (Type, Print) 3235 Elmora Avenue Baltimore, Maryland Elizabeth Tyson 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ₺ Buriel 2 □ Cremetion 3 □ Removel from State Cem. 01-15-99 Laurel, MD MD. Nat'l Mem.PK. 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility Baltimore, Maryland 21. Signature of fidneral Service Licenses leen WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or confdications that caused the deaf shock, or heart failure. Usi only one cause on each line. Approximete Intervel Between Onset end Deeth De not enter the mode of dying, such as cardiec or respiratory errest, Immediate Ceuse (Finel disease or conditi-resulting in deeth) week Sepsis Due to (or es e consequence of). Physician/Medical Examiner Ulcers Imonth ibi tus Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of) 4 months Immobility Due to (or es e consequence of): Accident erebral Vascular tmonths 23b. Did tobacco uss contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert 1. 1 Yes 2 No 3 Probably 4 Unknown longestive Heart Failure, Dementio à 24b. Were autopsy findings avellable prior to 24e. Wes an autopsy performed? completion of ceuse of death? 1 Yes 2 PNo 1 Yes 2 No Be 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 PNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) OL. 27. Manner of Deeth 28e. Dete of fnjury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Naturel 5 Pending 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide edicai 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end manner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end menner stated. (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certified 29c. License number D 51185 Musin

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State Registrar

**Funeral** 

Director

28a-f show

7 is marked other than "natural", or items 23s or 28s-f shot traumstic event, the Mourcel Exeminer must be notified at

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Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 28s
and Injury or other traumatic event, the Medical Exercises 2006.

Physician /Medical

**Examiner** 

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within 24 hours after death To the Funeral Director: , completaly filled in by the

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The law requires that the death certificate be axecuted

P.O. Box 68760.

Division of Vital Records,

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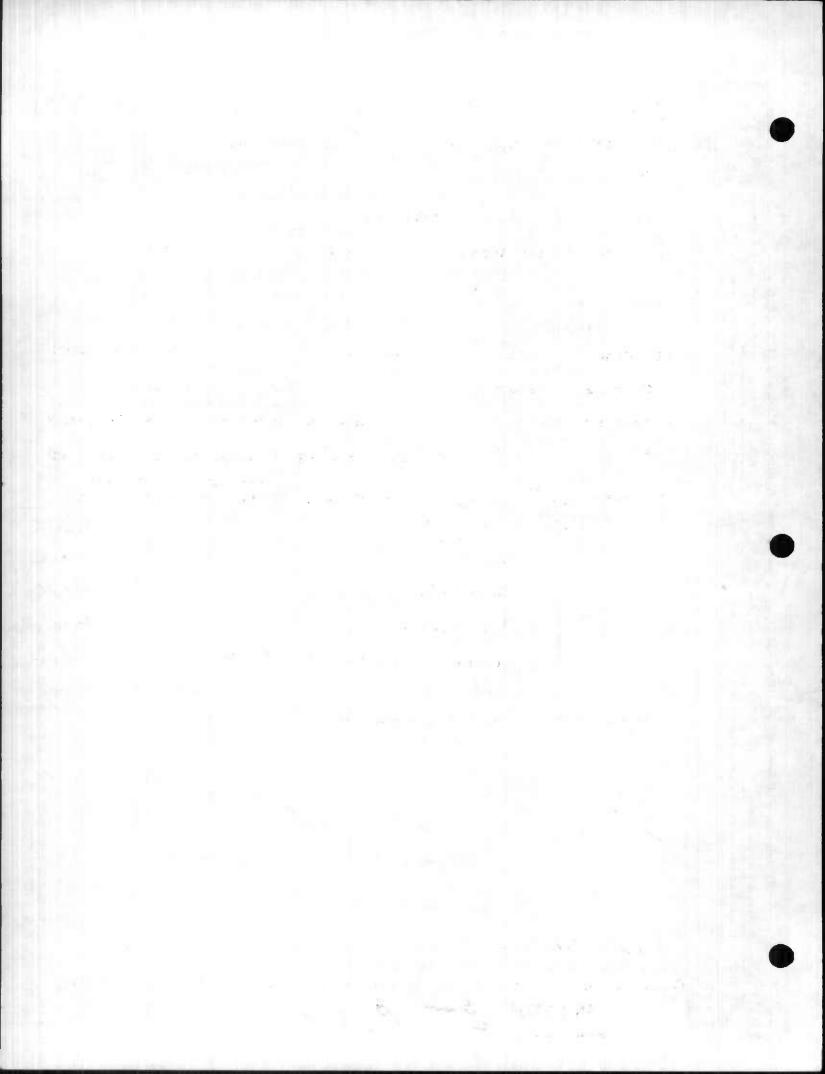
5 1999 JAN

Colleen Christmas, MD

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

5505 Hopkins 32. Registrar's Signeture

Bay view Circle, Baltimore, Maryland



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death JANUARY JESSIE JUNE DAVIS 1999 5:35 P.M. 4e. Fecliity Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD If Under 1 Yeer 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Deys 574-18-2308 1 M 2 KF Months Hours 6 June 22, 11922 New Usual Residence of Decadent 10b. County 10c. City. Town or Location 10d. inside City Limits saltimore 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2501 21120 Bond Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☑Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry New YORK Elementary/Secondery (0-12) College (1-4or 5+) 12 eacher SchoolSystem 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 6. M'Lane Ralph 6. Fradick Edith 19a. informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2501 Bond Road Parkton, MD 21120 Paul Davis 20b. Place of Disposition (Name of cametery, cramatory or other place)

Evans Forera (hapel- Jan. 15, Bel Air, P.A. 1999) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriai 2 Cremation 3 ☐ Removal from State Forest Hill, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Chapel 21. Signature of Juneral Senece Licens Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. List only one ceuse on each line. Approximate interval Between Onset end Deeth tmmediate Cause (Fine) disease or condition resulting in death) Due to (or es e consequenca of). Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause ot deeth? 24e. Was en eutopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28h. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pteca, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end manner stated. 29a. Certifier

or Attending Physician: The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Director

Funeral

Be Completed by

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Deperment of Health and Mental Hygiene. Important: If fam. 21s marked other than "natural", or itama 23s or 28s-f show any Injury or other traumatic event.

**Physician** /Medical

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Physician/Medical Examiner

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Be Completed

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Certification:

Medical

Baltimore, Maryland 21215-0020

To the Hospital o within 24 hours aft To the Funeral DI completely filled in

State Registrar

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 2 31. Date filed (Month, Day, Yeer)

29b. Signature and title of certifier

JAN 1 5 1999 32. Registre's Signeture

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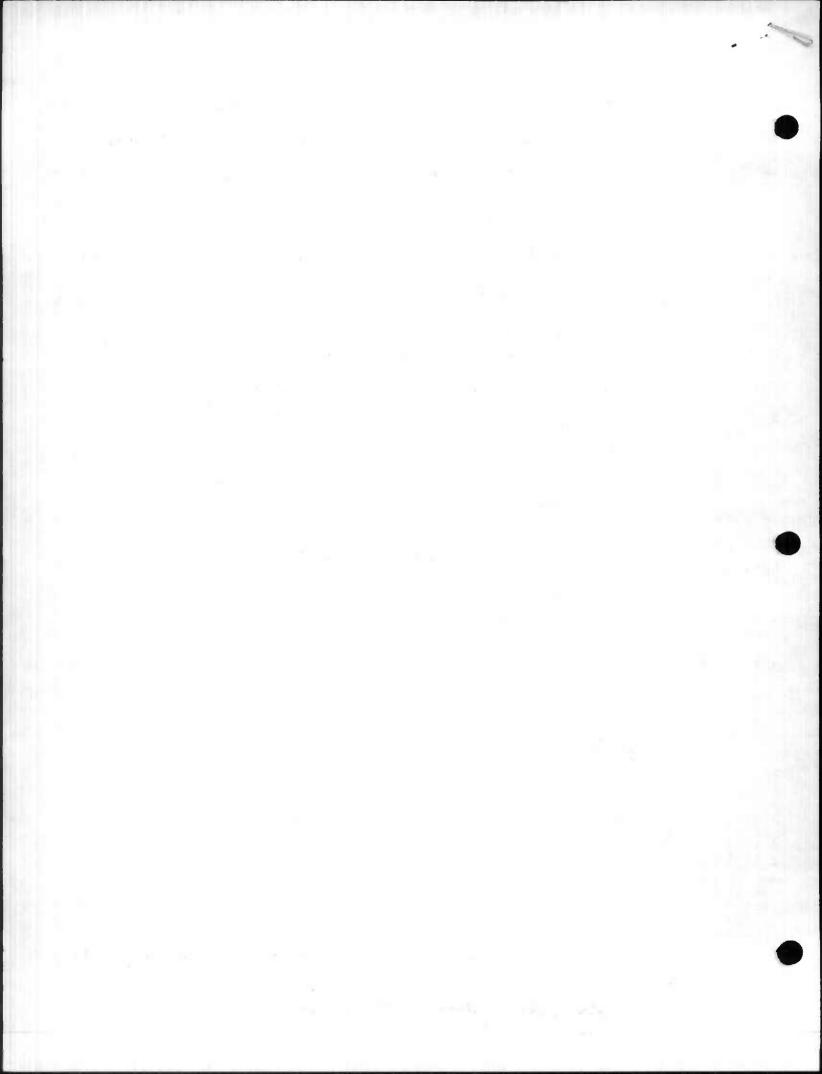
29c. License number

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29d. Dete signed (Month, Dey, Year)

JANUARY 14, 1555

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Latoya Duncan 1999 0746 lanvary 12 4b. City, Town, or Location of Death 4e Facility Nema (If not institution, give street and number) 4c. County of Death HOSPITE! Baltome City HOPKINS Khrs 5. Social Security Number UNK 6. Sex If Undar 1 Yaar | If Undar 24 Hrs. Birthplece (State or Foreign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 10 M 2 F Months Hours Yrs. 15 1998 MARYLAND Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 X No **MARYLAND** PALTIMORE PERRYHALL 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 5120 FORGE ROAD 21128 U.S.A. 14. Race - American Indian, Black, White, atc. 12. Wes Dacedent Ever in U,S. Armed Forcas? 13. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11 Marital Status 1 Yas ZXNo ff Yes, Giva Yaar or Datas: Navar Married 2 Marriad 1 Yas 20 No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) N/A N/A 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middle, Maidan Sumama) TROY E. DUNCAN PATRICIA GREEN 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Straet end Number or Rurel Route Number, City or Town, Stata, Zip Coda) Troy Duncan/Father 5120 Forge Rd., Perryhall, Maryland 21128 20b. Place of Disposition (Nama of camatery, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition XX Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata HOLLY HILLS MEMORIAL 1-16-99 MIDDLE RIVER, MARYLAND 4 Donation 5 DOthar (Specify) 21. Signature of Europal Syst 22. Nama and Addrass of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 23a. Part Filter Ta disaasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Interval Batween Onsat end Death Immediata Causa (Final disaasa or condition resulting in daath) e. Pulmonory Hypertersion
Dua tolor as a consaduance of): INREK Pulmonary Hypeplasia
Due to (of as a consequence of): Sequentially list conditions, if any, laading to Immadiata ceuse. Enter Underlying Causa (Disaasa or Injury that initieled evants resulting in death) Last Eventration 1 month Diaphragnaho Dua to (or es a consaquance of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dfd tobacco use contributs to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 2 No 25. Was cesa refarrad to medical axaminar? 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred Natural 2 Accidant 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Steta) 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Spacify) 4 ☐ Homicide

The law requires that the death certificate be executed Records, P.O. Box 68760. Physician: or Attanding

physician and the buriel-transit ed by the e signed by t peen hes certificate this After this thin 24 hours after death. the Funeral Director: Af mpletely filled in by the fu death. within 2

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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**Physician** /Medical

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Physician/Medical

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29a. Cartifiar (Check only one)

29b. Signature end titla of certifiar

31. Data filed (Month, Day, Year)

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Funeral

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Registrar

MD 30. Nama and entress of person who completed ceuse of death (Itam 23a) (Type, Print) m.

5 1999

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Mospital Intensive Case Unit Hopkins

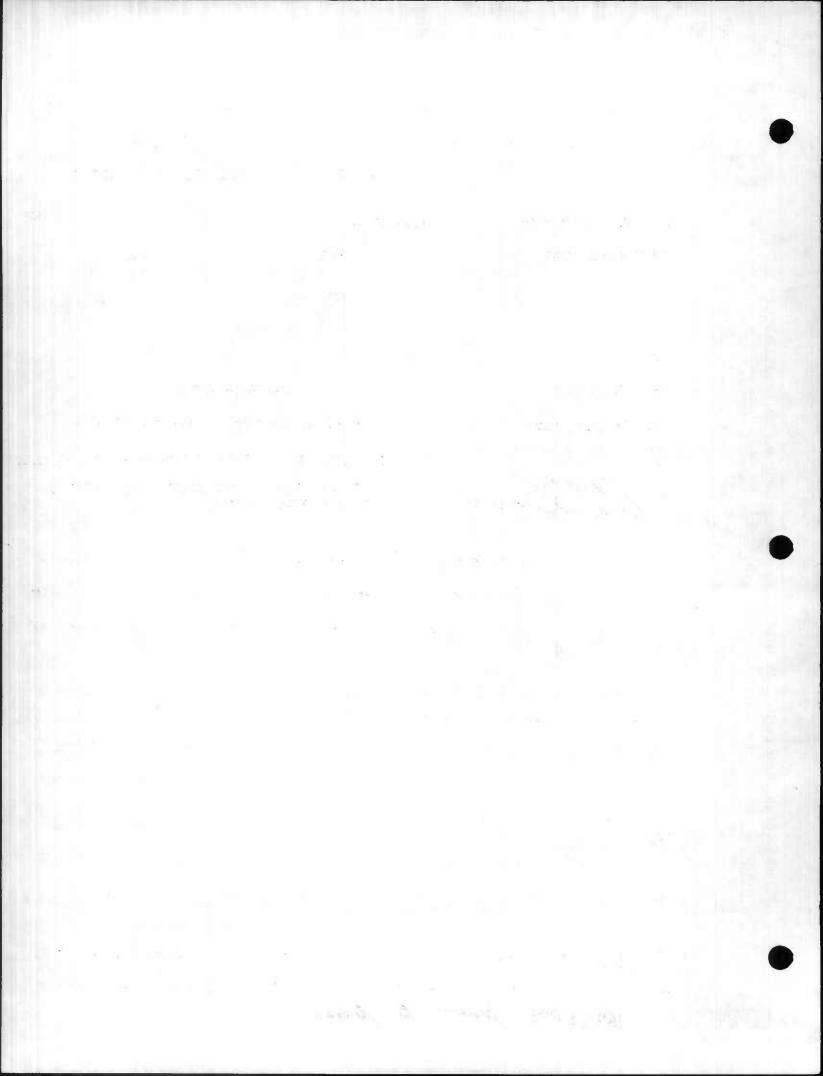
Certifying Physician: To the best of my knowledge, daeth occurred at the time, date end place, end due to the ceuse(s) and mannar as stated.

Limited Examinar: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s)

29c. Licanse number

D 48128

29d. Data signed (Month, Day, Year)



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m RAYM		ID GRAHAM  1. Decedent's Nama (First, Middle,	Lant	-	Cei	rtificate	of L	Death	2. Date of E	Reg. N	lo.		3. Time of Death	
Physicia		Raymond A. Graham							Month JANUA	D	)9, 1	Year	02:30 AM	
/Medica Examine	_	4a Facility Nama (If not institution, 3238 GULFPORT					Ib. City, Town, or Lo	cation of Dec	eth 4c. County of Death NA			02.30 Par		
Funeral Director		5 Social Security Number		T Ana (In urs last hirthday) If Under 1				ar If Under 24 Hrs. 8. Date of Bir			31	place (Stete or Foraign htry) ID		
		Usual Residence of Decedent												
ehow d at		10a. State 10b. County		1	, Town or Lo							1	10d. Inside City Limits	
N III	Director	MD NA		Baltimore							X 🔀 Yes			
# 52 F	5	10e. Street and Number		10f. Zip Code						10g. C	itizen of	What Cour	ntry?	
h wil		1130 East No	th Aver	ue 21202				)2			USA			
da .	by Funeral	11. Marital Status 1 ☑Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes X2 M No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:			pecify Yas or No- o Rican, atc.) 14. Rac Bla Specif			ace - Amarican Indian, lack, Whita, atc. hify: Black	
TO The Render	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 9thGrade	Education grade completed) College (1- NA	4or 5+)	16a Decedent's Usual Occupation (Give kind of work done during most of work lifa. DO NOT use retired)  Unemployed				rking			nd of Businass/Industry		
T HOY	9	17. Father's Nama (First, Middle, Li						18. Mother's Name			en Suman	na)	- Aco	
d 2 should be h end Mentel 7 le marked o treumatic ev	<del>ှိ</del>	19a. Informant's Name/Relationshi				Gwendo	olyn Graham ral Routa Number, City or Town, Steta, Zip Code) 21201							
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ficate be physicia s the bur	edica	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		as a conseq									
the the	Ē	Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.											o the cause of death	
e law requires has been sign ge 2 should be	Completed by								pe	as an au riormed?		av	dara autopsy findings railable prior to implation of causa death?	
en: The la									15	Yas	2 ∐ No	7	Yas 2 No	
0 0 0	10	25. Was case referred to medical axaminer?	Hospital:				Cub	26. Place of Deat						
oding Physioth. It After this of funeral directions	Mion: 10	1 Nes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Data of		28b. Time of Injury	28c.	Injun Work	4 Li Nuising Ho	ma 5 Re 28d. Describ				SCENE	
or Attending effer deeth. Director: Affe i in by the fune	entication	3 ☐ Suicide 6 ☐ Could no 4 M Homicide determin	A 258, Place (	of Injury - At ho g, etc. (Specify	ma, farm, str	eet, factory, of	ffice		28f. Location City or T	(Street	and Numi	ber or Run	al Route Number,	

Medical Certification: To

To the Hospital or Attending Physicien: The law within 24 hours effer deeth.

To the Funeral Director: After this centificate has completely filled in by the funeral director,

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month,

29a. Certifier (Check only one)

29b. Signature and title of ce

death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

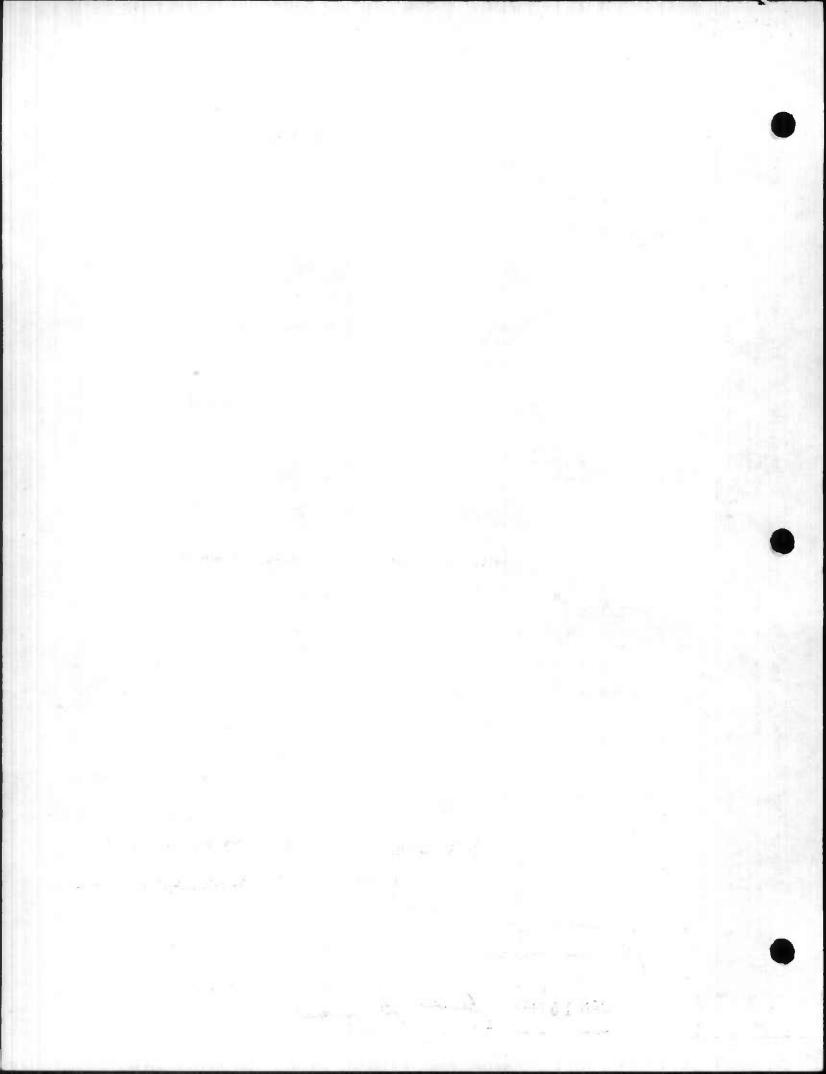
OCME

Baltimore, Maryland 21201

3036

29d. Data signed (Month, Day, Year)

JANUARY 09, 1999

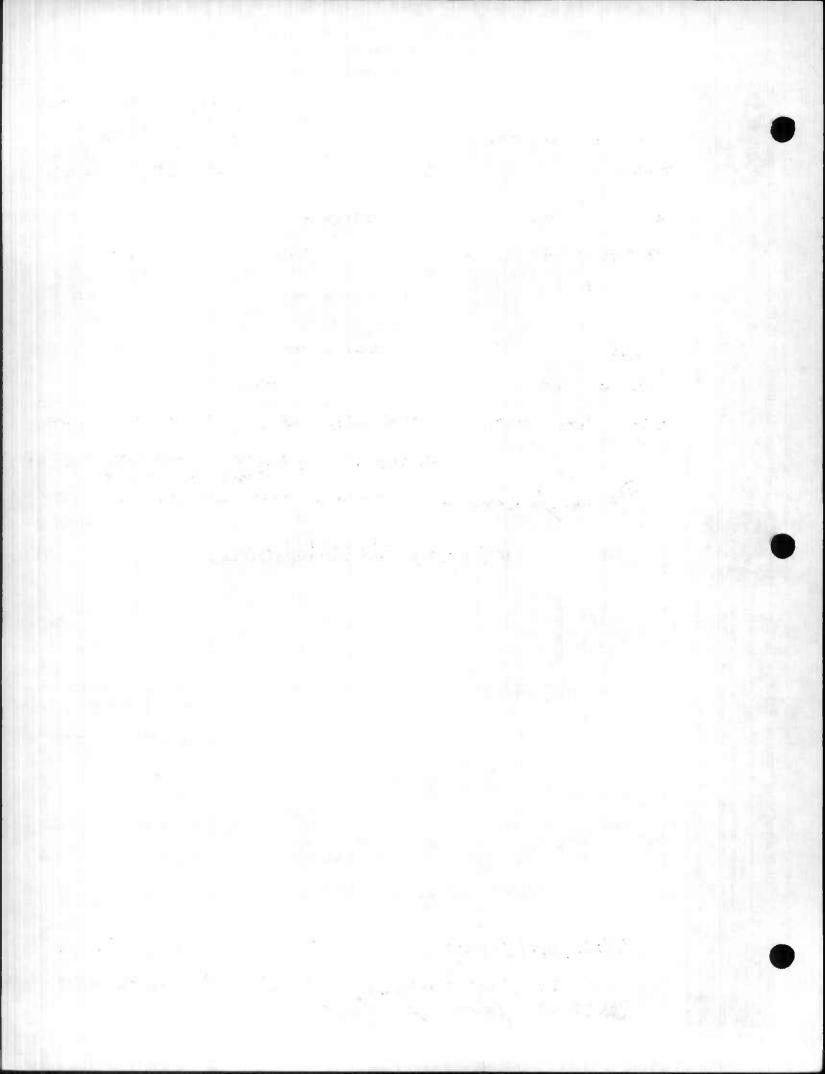


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State of Maryland / Department of Health and Mental Hygiene 9 0613

					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Cer	tificate o	f Death	Re	g. No.				
Physicia /Medica		1. Decedant's Neme	(First, Middle, Las	1)					2. Date of Deeth Month	eeth 3. Tima o				
		Leon T. Gibson Sr.							January			3:45p		
Exam		4a Facility Nama (If not institution, giva street and number)						4b. City, Town, or L		4c. County				
					e Apt. 208				more		N/A			
Funera Director		5. Social Security Nu. <b>250–10–25</b>	70 13	M 2□F	7. Aga (In yrs.	17 Yrs.	If Under 1 Ya Months De		8. Data of Birth (Month, Pay, Dec 17,	1921	_ Counti	aca (Stata or Foreign ny) arolina		
how		Usual Residence of D 10a. State	10b. County	7-10	10c. Cit	y, Town or Lo	cation		10d. Inside City Limits					
e Me	cto	Md	N.	/A			Baltin	ore		1 <b>X</b> Yes 2				
or 28	Dire	10e. Street end Num					10f. Zip Cod		10	g. Citizen of W	/het Count	ry?		
eth w	ra ra	5200 Bow	leys Lane					21206			USA	- toda-		
21215-0020 d within 72 hours after deeth with the Meryland glena. r than "natural", or flema 23a or 28a-f ahow than Med call Españner main be notified at	by Funeral Director	11. Marital Status 1 ☐ Nevar Marrie 3 ☐ Widowed 4		12. Was Dece Armed For 1  Yas If Yas, Give Year or Da	cas? 2 No a		Vas Decedent of Yas, specify C	of Hispanic Origin? (Spuban, Maxican, Puerto No Specify:	ecity Yes or No- Rican, atc.)		e - America k, Whita, e : <b>B1</b> .			
15-002 72 hours "natural",	eted	(Specif	15. Decedant's Ed	ucation da complatad)	completed) (Give kind of work d				sing 1	16b. Kind of Business/Industry				
within than the Man	Completed	Etamentary/Secon	College (1-4or 5+)  Iifa. DO NOT usa n				lired)			Concr	oto			
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☐ Saby	o Be		enry Cool	c				1 Gibson		ω,				
laryla 2 should and Men is marke	F	19a. Informant's Nar				19b. Mailir	ng Addrass (Str	eet and Number or Ru			Stata, Zip	Code) 21206		
		Lula B.	Gibson	(Wife	)			s Lane Apt				-2200		
other other		20a. Mathod of Dispo	osition		20b. F	Plece of Dispo	sition (Nama of natory or other)		7	Oc. Location -	_			
Peges nent of I			Cremetion 3 ☐ Othar (Spacify		tata			tery 1/16/	99	Pikesv	ille.	Maryland		
보 필립로급.		21. Signature of Fun	aral Sarvice Lican	600		22	. Name end Ad	drass of Facility Ca	ple Fune	ral Se	rvice	zar j zara		
B Coppe		21. Signature of Funaral Sarvice Licarreee 22. Name end Addrass of Facility Caple Funeral Service 5502 Winner Avenue Baltimore, Maryland 2121.												
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/Medical		Immediate Ceuse (Finel disaasa or condition a. Maliquant Mesotheliama 4 mont												
Examine		resulting In death)		8	Dub to (0	or es e consec		( 0 4 000						
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687 ifficete g phrys	edical	that initiated avants rasulting in daath) La	ast		Dua to (d	ras a conseq	uance of):							
G G	M			d										
	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the												
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	Completed								1 ☐ Ya	s 2000	1□	Yes 2□ No		
Vital I	Be (	25. Was case referre							th (Check only on	a)				
of Vita Physician: rithis certific oral director,	L <sub>o</sub>	1 ☐ Yes 2 ☑ N	io			ER/Outpatier			oma 5 Rasida			)		
ding P. After t	OD:	27. Mannar of Death 1 Naturat	5 Panding		f Injury h, Day Year)	28b. Tima o Injury		njury at Work?	28d. Dascribe ho	ibe how injury occurred				
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ours ours filled	O	29a, Cartifiar	Cortifying Phy	/sician: To tha	best of my kno	wiedge, daati	occurred at the	e time, data and place	and dua to tha ca	usa(s) end ma	nnar es st	ated.		
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ro the	Me	29b. Signatura and ti	itla of certifiar	100	1 0		29c. Lic	ensa number	25	29d. Data signad (Month, Day, Year)				
->		> (X10)	Pron A	adnot	tul)		7	15546	-	Trn 12 1999				
n		30. Nama and addra	ss of person who d	completed cause	a of death (Itar	n 23e) (Type.	Print) _	10014		1)	- 11			
60		Charles F	adaett.	us. 56	m/ 10	a Rai	en Bl	val., Bal	timore	s all	1239			
			7-101.	-		-	A		-	-	-			

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Joseph W. Guzzo January 11, 1999 12:00pm 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 9454 New Bridge Drive Potomac, MD Montgomery If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Days HEM 2□ F Yes 220-10-3147 March 20, 1917 PA Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas & No Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9454 New Bridge Drive 20854 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. 1 Yas 2 No If Yas, Give Year or Datas: 1 Nevar Married 25 Married 1 Yas 2 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 5± Engineer 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Samuel Guzzo Giovannina Oliverio 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 9454 New Bridge Drive, Potomac Maryland Joe Guzzo / Son 20b. Place of Disposition (Name of cemetary, crematory or other place) Date 20a Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Good Shepherd Cemetery , January 15,1999 Monroeville, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensee Victor P. Doda, Jr. 22. Nama and Addrass of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death tmmediata Causa (Final CARDIO RESPIRATORY EACLUNE diseasa or condition rasulting in death) Dua to (or as a consequence of): HEPATO CECLUCAR CARCINOMA Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Dereas 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

**Physician** /Medical Examiner

physician and s the burial-transit

signed by i

Box 68760

P.O.

Records.

Division of Vital

Hospital or Attending Physicien:

death.

hours after death

24 hours

To the Hosp within 24 hou To the Fune compietely fil

this

After

permit. Pages 1 and 2 should be file Department of Hasith and Mental Hy Important: If flem 27 is marked other eny injury or other traumatic event pages.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"naturel", or items 23s or 28s-f show police Examiner must be notified at

death

72 hours after

altimore, Maryland 21215-0020

Director

Funeral

Completed

Be

MD

Physician/Medical p Completed Be Certification: To

25. Was case referred to medical examiner?

1 Yes 2 TO

27. Manner of Death

XXNeturet

2 Accident

3 Suicide

29e. Certifier

4 ☐ Homicide

(Check only one)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 10 No

1 ☐ Yas B No

26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28c. Injury at Work?

28a. Data of Injury (Month, Day Year) 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

XIX Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifier

5 Pending

investigation

6 Could not be

29c. License number 208470 29d. Data signed (Month, Day, Year) JAN.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10400 CONNECTIENT Eugene P. Libre MD ICENSINGTOW, MB

MO

28b. Time of

State Registrar

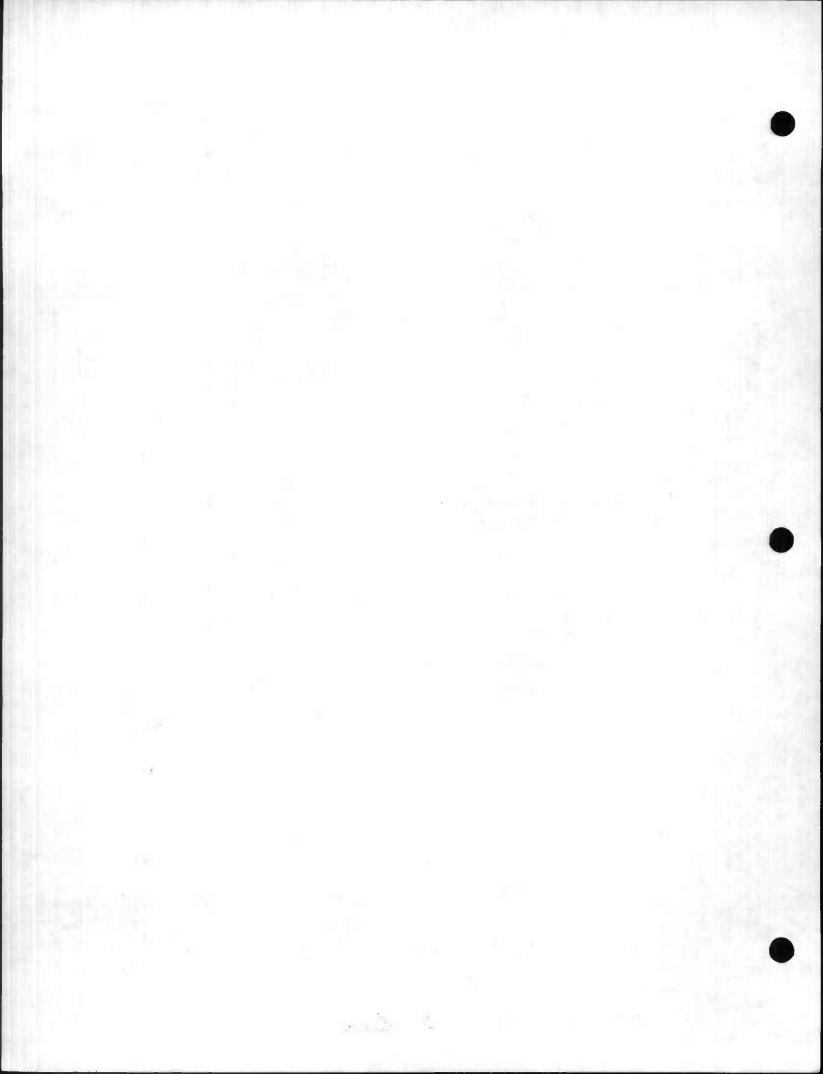
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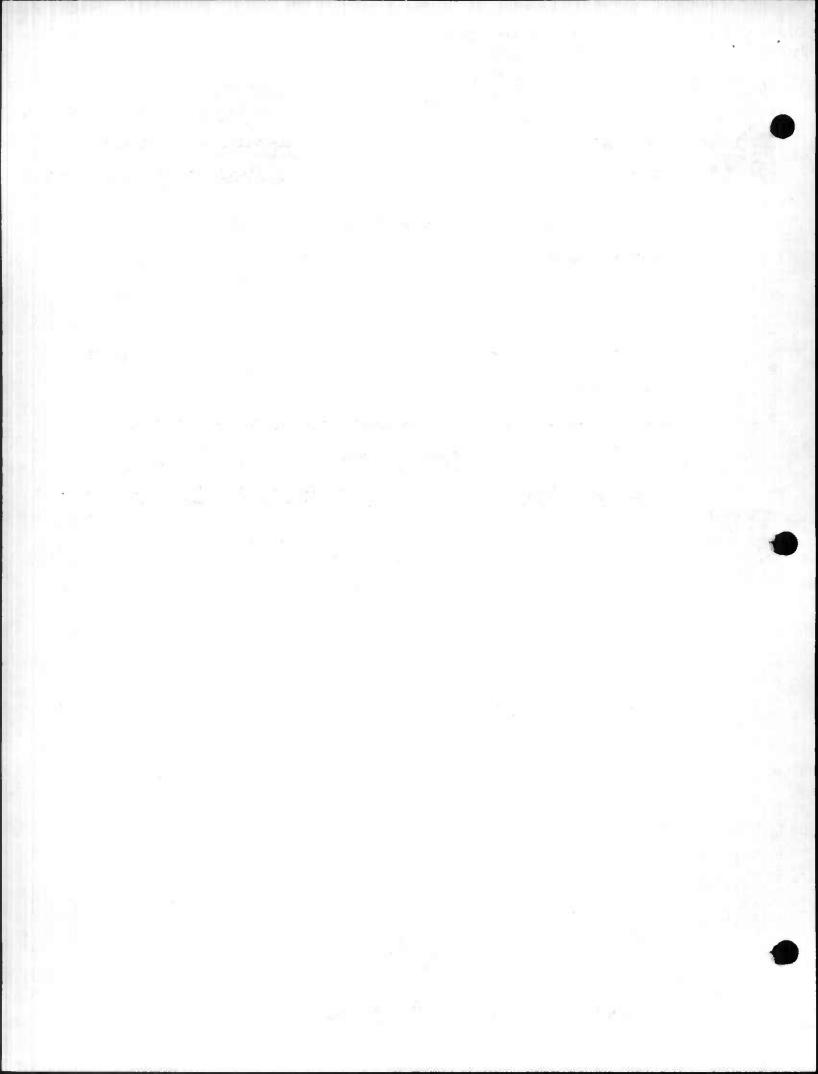
31. Data filed (Month, Day, Year)

32. Registrar's Signatura

Sparks



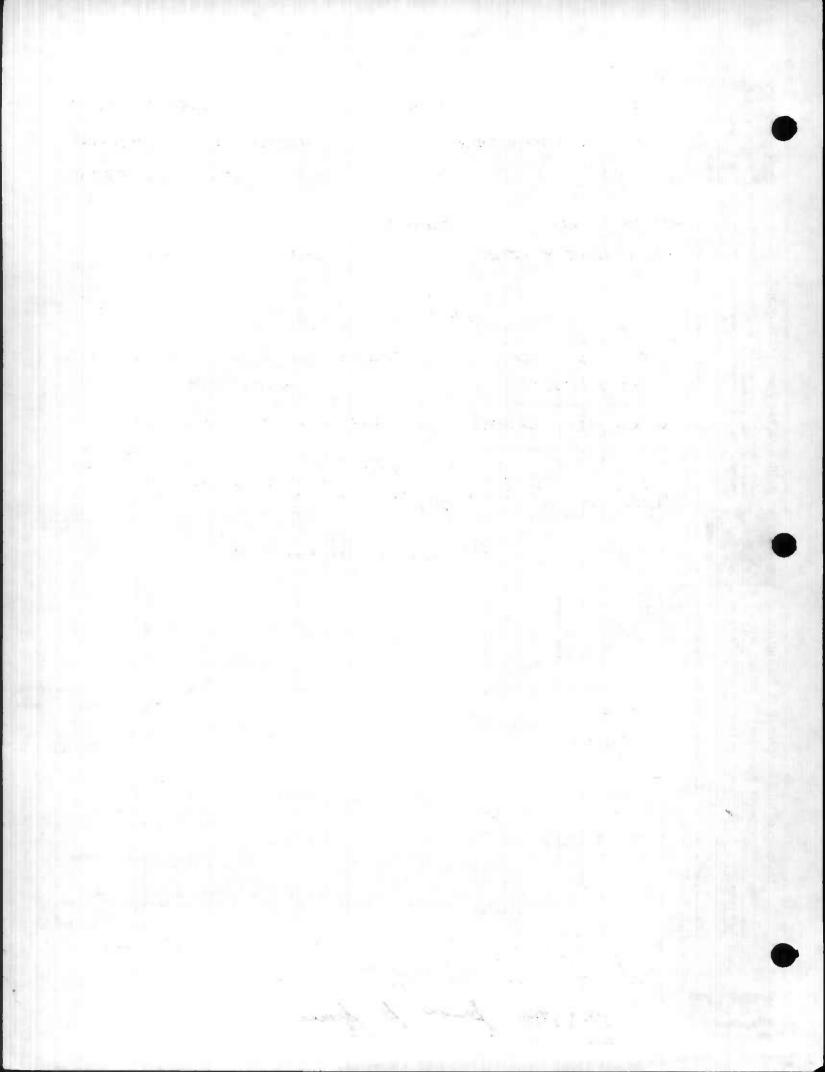
		Certificate of Death  1. Decadent's Nama (First, Middla, Last)  2. Data of Death 3. Ti										3. Time of Death		
Physici		Erna I. Gordieyeff							Month	Day Year				
/Medio		4a. Facility Name (If not institution, giva street and number)						4b. City, Town, or I	January Location of Death	4c. County o		3:05 р.п		
		BROADMEAD						Cockevsv	eysville Baltimore					
Funerai		5. Social Security Number		7. Aga (In yrs. la	st birthday)	If Under		If Undar 24 Hrs.	8. Data of Birth	Dare.		aca (Stata or Fore		
Director		050-24-7344 Usual Rasidence of Dacedant	1□M 2⊠F	91	Yrs.	Months	Days	Hours Min.	8. Data of Birth (Month, Day, April 25	, 1907 <sub>Z</sub>	Count gier	gierz, Poland		
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the Maryle 28a-f shor	Funeral Director	MD Balt	imore	Co	ockevs	ville					1 ☐ Yas 2 🖾 ñ			
	ire	10e. Street and Numbar				10f. Zip			1	0g. Citizan of Wi	nat Count	ry?		
23a or	a	13801 York Ro	ad				210	030		US	Δ			
or Items	nec	11. Maritel Status	12. Was Deca	dant Evar in U,S	3. 13.	Was Deced		lispanic Origin? (S an, Mexican, Puart	pecify Yes or No-	14. Race	- Amarica			
	by	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	ed 1 ☐ Yas If Yas, Giv Yaar or De	2 No a	1 □ Yas 2X N				o r noun, etc.)	Bleck, Whita, atc.  Specify: White				
	Completed	15. Decadant (Specify only highas	s Education		16a. Decedent's Usual Occupe (Giva kind of work dona d lifia. DO NOT usa ratired) Secretar			etion	ting	16b. Kind of Bus	iness/Ind	ustry		
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should be find Mental I	2	Robert Lubna	u					E11a	a Bych					
2 sho and is me		19a. Informent's Name/Reletionsh			19b. Maili	ng Address	(Straat	and Number or Ru	ral Routa Number	City or Town, S	tata, Zip	Coda)		
1 end 1 Health am 27 I		James Peacock/A	ttorney		105	Bonnie	e Hi	11 Road	Towson, N					
permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Mode.		20a. Method of Disposition  1 ☐ Burial 2 🖔 Cremation  4 ☐ Donation 5 ☐ Other (Sp		Stata Balt	matary, crei	osition (Name matory or of Wash	na of thar plac ling	ton j	Tan. 13,	20c. Location - C		vn, Stata		
Departi Departi Imports any inju		21. Signature of Funeral Service t	isonison	OT CII	22	<ol><li>Nama an</li></ol>	d Addra	ss of Facility						
20129		Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093												
Physician				ausad tha daath.	Do not and	tar tha mode	e of dyln	g, such as cardiac	or raspiratory arra	ist,		Approximete Interval Batwaan		
		23a. Part Pintar the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiral shock, or heart failure. List only one cause on each line.									Onset and Deeth			
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Ine law requires that the death certificate be executed attentions been signed by the ettending physician and page 2 should be detached for use as the buriel-transit	by Phy	Alzhe	imer's	ner's dementio					1 🗆 Ye	1 Yes 2 No 3 Probably 4				
been signature	eted	COPD 24a. Wes en eutopsy performed?							n eutopsy ned?	com	re autopsy findings lleble prior to apletion of causa			
sician: The law certificate hes t lirector, page 2 s	Completed								1 ☐ Ya	s 2 No	of d	áath? Yas 2⊡ No		
rtifice ctor,	Be	25. Was case rafarrad to medical axaminer?						26. Place of Daa	th (Check only one	e)				
rnysician: rthis certific rai director,	ို	1 Yas 2 No	Hospitel: 1 🗆 Ir	patient 2 E	R/Outpatier	nt 3 DO	A Oth	er: 4 (2) Nursing H	ome 5 Rasida	nca 6 □Othar	(Specify)	)		
Afte		27. Manner of Daath 1 ☑ Netural 5 ☑ Panding 2 ☑ Accident invastig	(Monti	28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Dascribe how Injury occurred							d			
or Attenda efter death. Director: A I in by the fo	Certification:	3 ☐ Suicida 6 ☐ Could no datamii	ad 286. Place	28e. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify)					28f. Location (Straet and Number or Rural Route Number, City or Town, State)					
vithin 24 hours efter to the Funeral Dir.  To the Funeral Dir.  Completely filled in	edical C	29a. Cartifiar (Check only one)	Physicien: To the t	sis of axaminatio	adge, deeth	n occurrad a	it the tin	ne, data and place, pinion, daath occur	, end due to tha ca rrad et the tima, da	use(s) end meni ite and place, en	ner as ste	eted. tha causa(s)		
ithin omple	-	29b. Signature and title of certifier	end mann	ai steted.		29c	Licans	numbar	20	d. Data signad	(Month D	lav Vaar)		
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7	-	20 Name and all all all all all all all all all al	a lar	roul	MA	A	V	100%	_	1///	17	7		
		30. Neme and address of person w	ARROL	of deeth (Item 2	(Type,	Print)	, 1	Wort R	d Car	Keys	10/	1/ MY		
		31. Date filed (Month, Day, Year)			1	007		7	- 100	1000	0110	2111		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 1 per F.H G-767 1/15/99 reb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Corray. 7:40 BW FRANCIS JR. JANUARY /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN
If Under 1 Year | If Under 24 Hrs. | 8. Date
Months | Days | Hours | Min. | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Mont NORTH WEST MEDICAL CENTER BALTIMORE 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F Yrs. Director 219-10-4286 JAN. 29, 1928 MARYLAND Usual Residenca of Deceden the Maryland 10e. State 10b. County Items 23a or 28a-f show her must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1303 E. LAFAYETTE AVENUE 21213 Funeral u.s.a. death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) n "natural", or items 72 hours after 12 Yes 2 No
If Yes, Give
Year or Dates: 1-10-51 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify AFRO-AMERICAN by 3 ☐ Widowed 4 ☐ Divorced 1-9-53<sub>16e. Decedent's Usuat Occupation</sub>
(Give kind of work done during most of working life. DO NOT use retired) be filed within 72 houts! Hygiena.
d other than "natura Completed 15. Decedent'a Education (Specify only highest grede com 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH POLICE OFFICER BALTIMORE CITY permit. Pages 1 and 2 should be file Department of Health and Mental Hyy Important: If flem 27 is marked othe any injury or other traumatic event, bloca. 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be FRANCIS GRAY, SR. RAVINE SIMMONS 19a. Informant's Name/Retetionship (Type, Print) 19b. Malting Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1126 HARFORD TOWN DR. ABINGDON, MD. 21009 ROBIN A. GRAY / DAUGHTER 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Buriel 2 Cremation 3 Removal from State OWINGS MILLS, 4 □ Donation 5 □ Other (Specify) GARRISON FOREST VET. CEM JAN. 15, 1999 MARYL AND Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 21. Signature of Funeral Servica Licens 23a. Part1. Entair the disease, or complications that caused the family be not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each tine. 1412 E. PRESTON STREET BALTO, MD. Approximete Intervat Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical keel in Examiner Due to (or as a consequence of): Examiner The law requires that the death cartificate be executed and -trans Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician a s tha bunal-Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): 88 158 signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown CVA à 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed come performed' cartificata ha 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 200 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 27. Manner of Deeth 28c. tnjury at Work? 28d. Describe how Injury occurred Certification: Affart or Attending 5 Pending investigation aftar daath. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Sulcide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) à 24 hours after Funerei Dire 4 Homicide 1D Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(a) and manner stated. edicai 29e. Certitier To the Hoap within 24 hor To the Fune completely fi (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) mi 30. Neme and address of person who completed cause of death (trem 23a) (Type, Print) MPERM 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar



## Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death gara Month 9:50am Hor tense 10 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, giva straat and number) 4c. County of Death Bultimore Johns Hopkins Genatics Center If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Months Days 1□ M 2□ F 83 Yrs. MD 01-1-16 999-94-7847 Usuat Rasidanca of Dacedani 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 Yas 2 No NA Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5505 Hopkins Bayview Circle 21224 USA 12. Was Decadant Evar in U,S. Armed Forcas? 1 ☐ Yes 23∑ No If Yes, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Raca - American Indian Black, Whita, atc. 1 Navar Marriad 2 Married 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Dacadant's Education (Specify only highast grada complated) Eiamantary/Secondary (0-12) Collega (1-4or 5+) High Sch. Grad grad. various trades Busniss Laborer 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Collins George Edwards Georgia 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 2 1 2 0 2 19a. Informant's Name/Ralationship (Type, Print) Arthur Drager-Law Office 5 Light Street Suite #510 Baltimore, MD. 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition Burial 2 Cramation 3 Ramoval from Stata Voshell Mem. Gardens 01-15-99 Dundalk, MD. 4 Donation 5 Othar (Specify) 22. Nama and Address of Fecility 21. Signatura of Funarai Sarvice Licansee Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue e of complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, Approximata Intarvat Batween Onsat and Daath Immediata Causa (Final days Sepsis disaasa or condition rasulting in daath) Dua to (or as a consaquanca of): Bowel Obstruction Small 1 week Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Ceusa (Diseasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the causa of deeth? Part II. Other significant conditions contributing to deeth but not resulting in the underlying causa given in Part t. 1 Yes 2 10 3 Probably 4 Unknown Renal Insufficience Discase 24b. Were autopsy findings available prior to 24a. Was an eutopsy complation of causa of death? performed? 2 1 1 Yas 2 No 1 Yes 25. Was casa rafarrad to madical axaminar? 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Spacify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Daath 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending 1 Yas 2 No invastigation 2 Accidant

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**Funeral** 

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d 2 should be filed within 72 hours after death with the Maryler th and Mentel Hygiene.
7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Exertice must be notified.

permit. Pagas 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traun

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Examiner

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Physician/Medical

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(Check only one)

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Medical

24 hours a Hospital To the Hosp within 24 hor To the Fune complately fi

After

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2 Medical Examiner: On the basis of examinetion end/or Investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. Licansa number

1 Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and placa, and dua to the ceuse(s) end menner as stated.

29d, Data signed (Month, Day, Year)

29b. Signature, and titla of cartifiar

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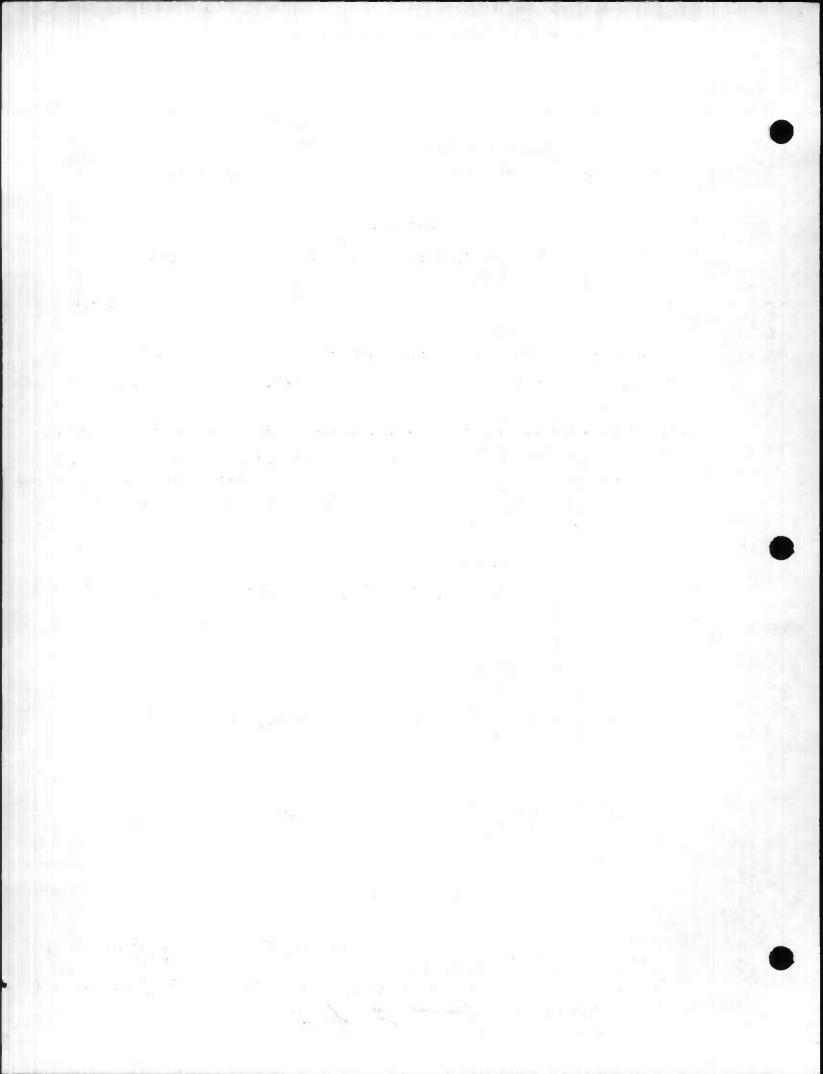
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

30. Name and addrass of person who completed cause of death (Item 23e) (Type, Print)

Colleen Christmas, MD 5505 Hopkins Bay your Circle Baltimore, Manyland 32. Ragistra s Signatura

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** RICHARD N. HENDRICK 14, 1999 JANUARY 3:00am /Medical 4b. City. Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE 1530 MEDFORD RD If Under 1 Year if Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Year) 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country)
 VA 6. Sex 4□ M 2□ F 5. Social Security Number **Funeral** Months 77 Vrs **Director** JANUARY 7, 1922 220-14-3409 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No N/A Director MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1530 MEDFORD RD. 21218 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Meritei Status Black, White, etc. 1 Never Married 2 Married XXYes 2 No 1 Yes 2 No Specify: Specify: BLACK by 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LABORER CHEMICAL . Pages 1 and 2 should be filed w ment of Health and Mental Hygier lant: if Item 27 Is marked other th lury or other treumstic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be UNKNOWN RUBIN HENDRICK 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1530 MEDFORD RD. BALTIMORE, MD 21218 PEARLINE WILSON(DAUGHTER) 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or once. GARRISON FOREST VET. CEM1-20-99 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 1721-27 N. MONROE ST. BALTIMORE, MD 21217 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final sepsis disease or condition resulting in death) Examiner Examiner Decubity physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or es a consequence of) Physician/Medical Due to (or as a consequence of) attending pl signed by the a 23b. Did tobacco uas contributs to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 No by 24b. Were eutopsy findings evallable prior to 24a. Was an autopsy Completed completion of cause of death? certificata has b lirector, page 2 s 1 ☐ Yes 2 PNo 1 ☐ Yes 2 No director. 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) funeral 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation in 24 hours.
the Funeral Director filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ave

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law requires that the death certificate be executed

or Attending Physician:

Hospital

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Division of Vital Records, P.O. Box 68760

with the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

Worle

State Registrar

31. Date filed (Month, Dey, Year) JAN 15 1999

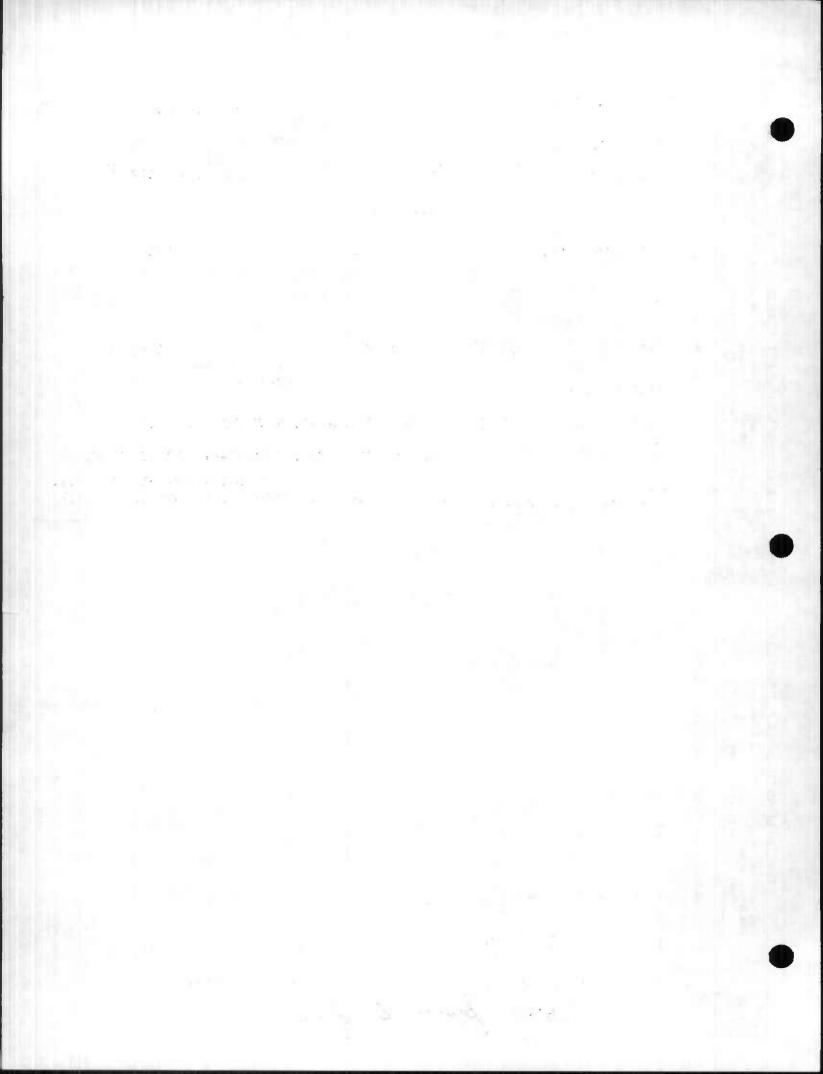
David

32. Registr 's Signeture

1 Jenberg

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

2400



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 440 Am PAUL 1999 HUDGENS 0/ 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death N/A BALTIMORE HOSPITAL SECOURS BON 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day.) 7 1 Yrs. Months Deys Hours Min. 2-11-27 9. Birthplece (State or Foreign Country) MD. 6. Sex XXM 2□ F 5. Sociel Security Number 216-20-9059 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits L□ Yes 2□ No BALTIMORE 10f. Zip Code 10g. Cifizen of Whet Country? 10e. Street end Number 1917 W. SARATOGA ST. 21223 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 11 Maritel Status Never Merried 2 Married 1 Yes 2 No 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) LABORER BUILDING SUPPLIES 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) JOSEPH BENNETT NANCY HUDGENS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1917 W. SARATOGA ST. BALTIMORE, MD 21223 NANCY JONES (MOTHER) 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State DULANEY VALLEY MEM. GARDENS 1-15-99 COCKEYSVILLE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility PHILLIPS FUNERAL HOME, P.A. 21. Signatura d' Funeral Service Licensee 1721-27 N. MONROE ST. BALTIMORE, MD 21217 kalo Approximete Intervel Between Onset end Deeth 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. CONGESTIVE Immediate Ceuse (Finel HEART FAILURE DAY diseese or condition resulting in deeth) Due to (or es e consequence of): CORONARY IYEAR ARTERY DISEASE Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) IOYEARS HYPERTENSION Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RENAL FAILURE 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy ANEMIA DE HYDRATION 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ UNo 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Netural 1 Yes 2 No

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**Physician** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nn: If Item 27 Is marked other than "natural", or ite nry or other traumatic event, "predical Exprise rry or other traumatic event, "predical Exprise

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Examiner Physician/Medicai by Completed Be To Certification:

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A 24 hou... Hospital 24 hours e edicai To the Hosp within 24 hos To the Fune completely fi

2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one)

29b. Signeture end title of certifier

SUTA M.D.

29c. License number D33407 29d. Date signed (Month, Day, Year) 99. 1114

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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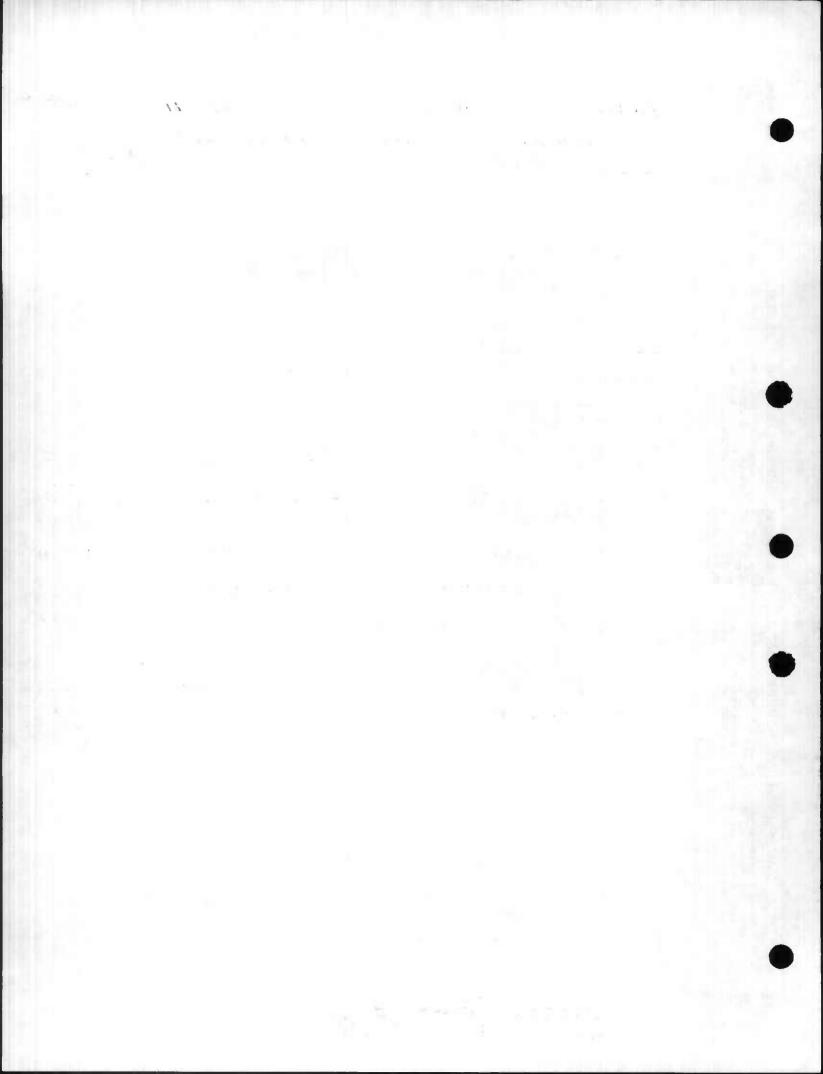
WISE AVENUE BALTIMORE, MD 21222

28f. Location (Street end Number or Rural Route Number, City or Town, State)

Registrar

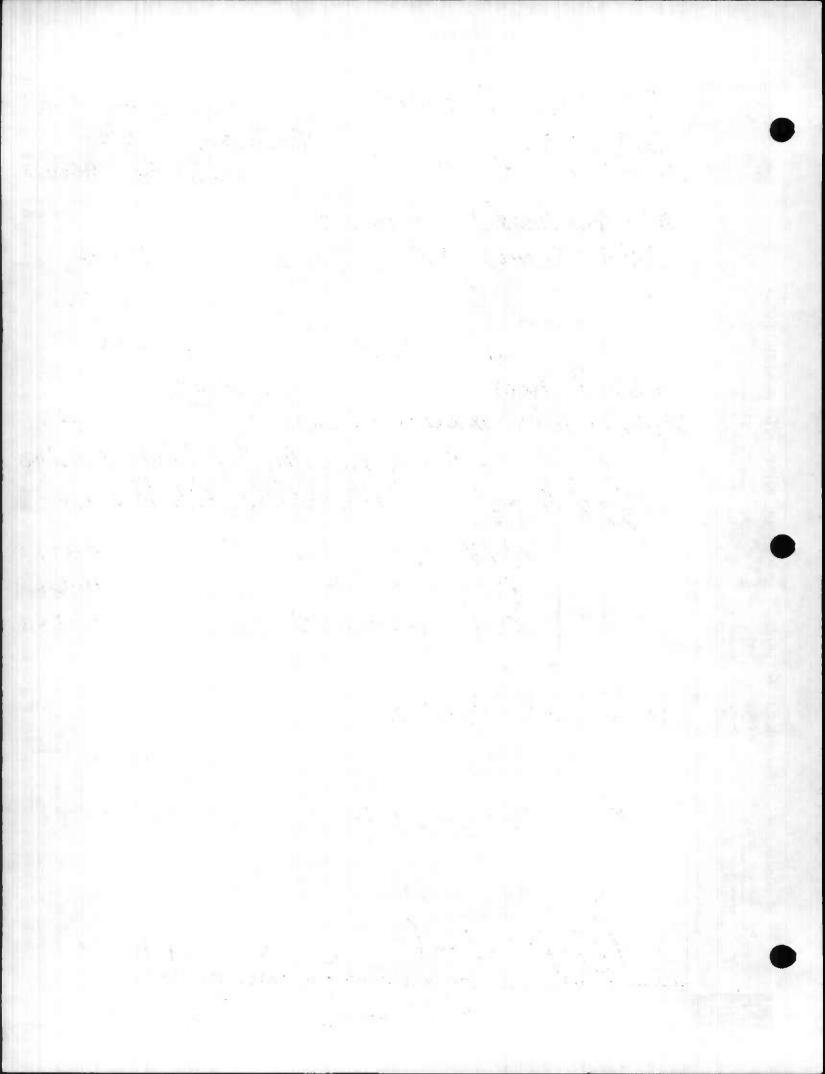
31. Dete filed (Month, Dey, Yeer)

32. Registra s Signature JAN 1 5 1999



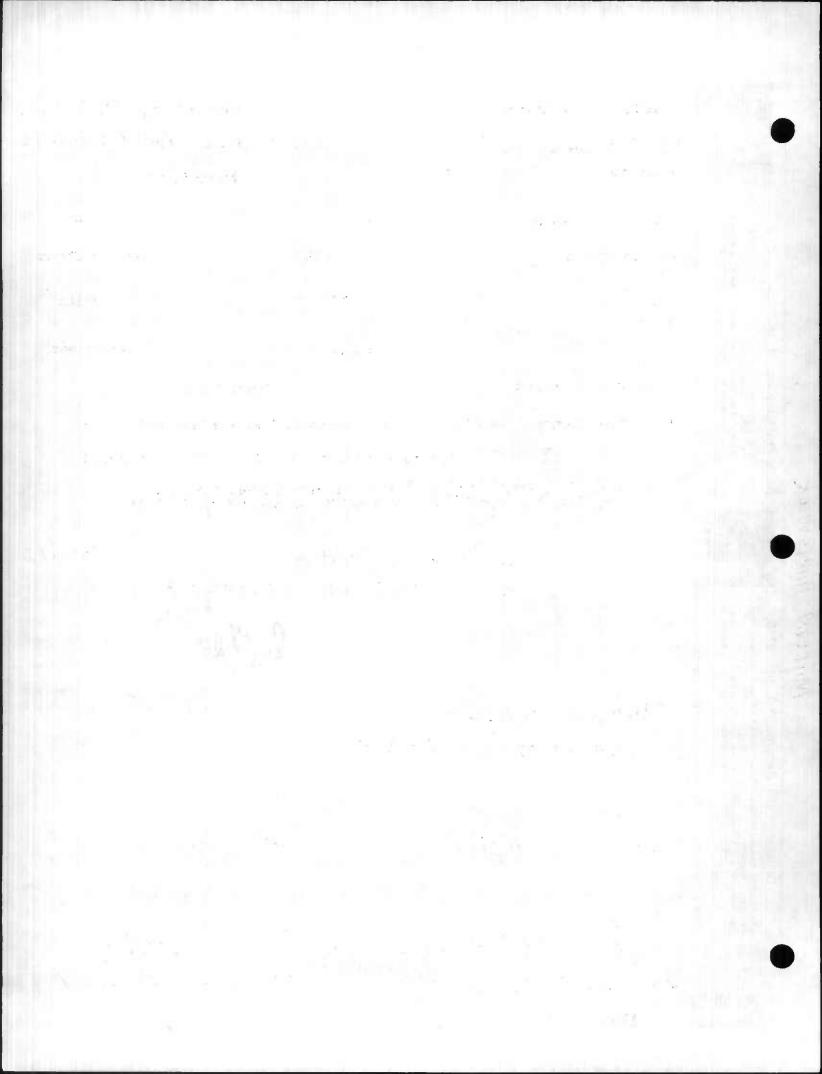
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death Af not instruction, give sweet and number) **Examiner** 9. Birthplace (State or Foreign County) ROUNA If Under 1 Year Date of Birth (Month, Dey, lest birthday) **Funeral** Days 1 M 200 Vrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 24 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funerai death v Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgln? (Specify Yes or If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black filed within 72 hours after 1 Never Married 2 Married 1□ Yes 21 No Specify: λq 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) eacher Gyrs. 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 end 2 should be 1
Department of Heelth and Mentel I
Important: If Item 27 is marked of
any injury or other traumatic ava CONG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Neme/Relationship (Type, Print) 2/2/3 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Commation 4 Donation 5 Dolher (Specify) 21. Signeture of Fundami Service Licenses Approximate Interval Between Onset end Deeth ease, of complications that caused the deeth. Do not re. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last attending physician end for use as the bunal-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai signed by the a Part II. Other significant conditions contributing to death out not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco uss contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 s 2 No 1 Yes 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3000A 1 Yes 1 Inpatient Certification: To 2 ER/Outpatient 28c. Injury at Work? 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide To the Hospital 1 Directifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edicai 29b. Signature and 29d. Date signed (Month, Day, Year) o completed ceuse of deeth (Item 23a) (Type, Print) 936 West North Ave. Balt. 21217 Md. Tyson M.D. Richard F. 31. Date filed (Month, Dey, Year) 32. Registrer's Signature Registrar Car March



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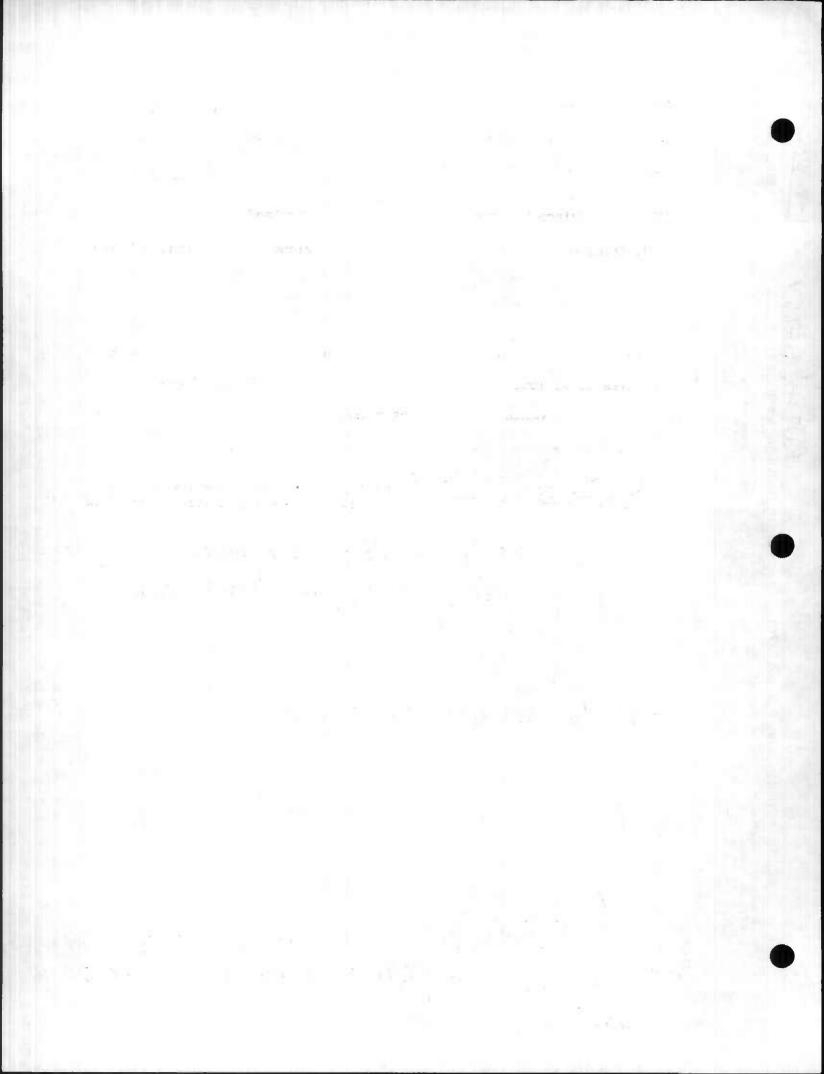
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		/Medical	Mariin Hartswick								RY 4,	1999	6:43 pm	
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		forms 23e or 28e-f show from the portified as former and be notified as Funeral Director	904 3rd Avenue 15027									United States		
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	Baltimore, Maryland 21215-0020	of of	20a. Method of Disp	osition Cremetion 3 🕅	<b>K</b> emoval from Sta	Cerri	e of Disposition of D	ry or other ple		Dete	20c. Location -			
	tim	t. Pa tment tant:	4 Donetion 5 Other (Specify)  Sylvania Hills Memorial Park Jan. 9, 1999 Rochester, PA										, PA	
X	Bal	pemit. Pag Depertment Important: I any Injury o	21. Signature of Funeral Service Licensee Victor P. Doda, Jr.  22. Name end Address of Fecility Charles L. Stevens Funeral Home, Inc.											
SWICK			1501 East Fort Avenue, Baltimore MD 21230											
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		To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,  Medical Certification: To Be (	one)	7	end menne	steted.								
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PV)	1	State	31. Date filed (Monti	h, Dey, Year)	82. Red	istrer's Signetur	200	V-		3000	140	011	70/	
4		State Registrar	TAM	15 1999	Sente	me L	1. 10	ackel						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 10:10pm Ruth P. Heisey January 8, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Prince Georges Larkin Chase Nursing Home Bowie, MD If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Funeral Days 1 ☐ M 25 F Months Hours 98 177-01-7144 **Director** December 20,1900 OH Usual Residence of Decedent 10a. State the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itema 23s or 28s-f show the Medical Examiner must be notified at Yes 2□No MD Prince Georges Stevensville Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 304 Irene Way 21666 United States Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 1 Yes XX No
If Yes, Give
Year or Detes: 1 □ Never Married 2 □ Married 1 Yes XX No Specify: Specify: White p 3℃Vidowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 laryland 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be 9 Charles Elmer Tower Edith Maria Simons Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2806 Bosworth Lane, Bowie Maryland 20715 Health em 27 Nedra P. Evans / Daughter Department of Heal Important: if item 2 any injury or other pnce. altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Uhk. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bever Center Cemetery Beaver Center, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximately 1100.

1501 E. Fort Avenue, Baltimore Maryland shock, or heart failure. List only one cause on each line. 21230 Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine physicien and the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760. requires that the death certificeta be Physician/Medical 88 950 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Nnknown reast Carcinoma: signed t Division of Vital Records, 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? page 2 s hes 2 X100 1 Yes 1 ☐ Yes 2 ☐ No cartificate Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) 1 Yes 2000 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To this 27. Manner of Death 1 Matural luneral 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Attending 5 Pending investigation 1 Yes 2 No 24 hours aftar deeth. Funeral Director: A 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 5 Hospital 11 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. Licanse number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certific 30. Name and address of person who completed cause of death (Item £3a) Type P 32. Registrar's Signature 31. Date filed (Month, Dey, Year) State Registrar JAN 1 5 1999



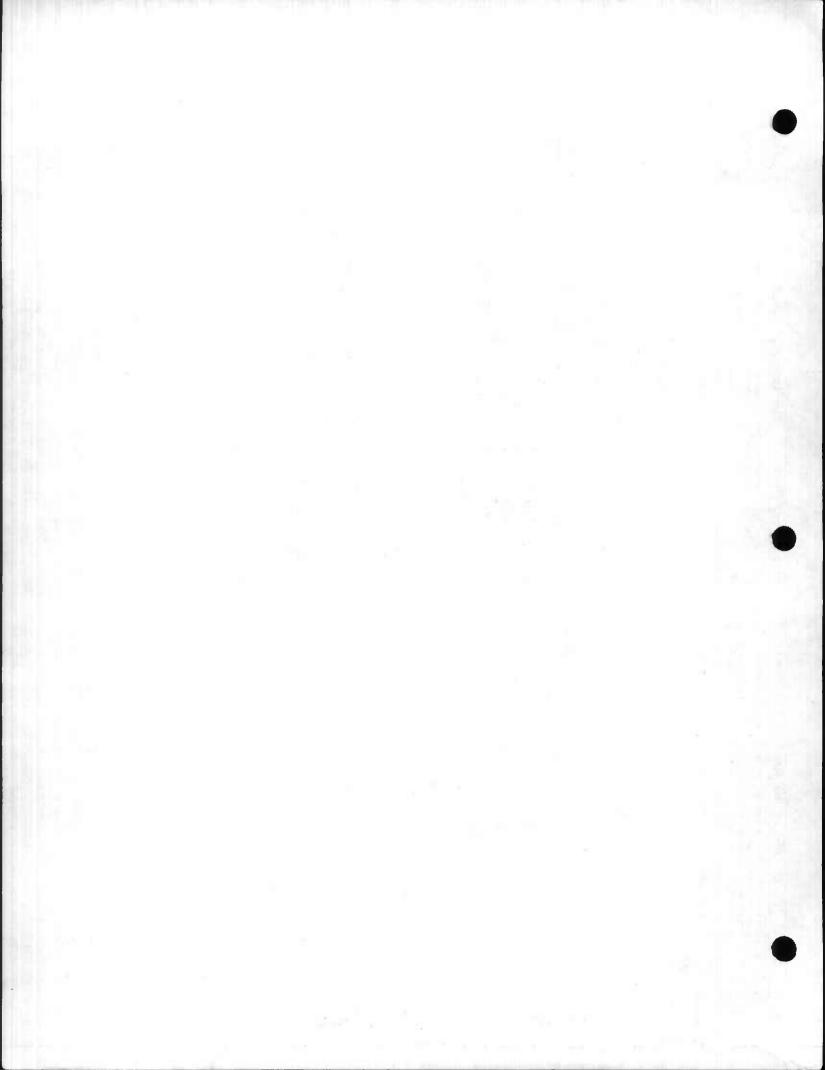
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Rose J. Ireland January 10, 1999 5:45mm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Habour Inn Convalescent Center If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Funeral Days 1 M 25 F 219-16-5307 80 Director June 10, 1918 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Yes 2□No Directo N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with flams 23s or liner must be b 21230 United States 1726 Byrd Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 전전No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Stalus i Hygiene. other than "natural", or item Black, White, elc 1 Never Married 2 Married the Medical Exami White Saltimore, Maryland 21215-0020 1 Ves 2 No Specify Specify à Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit. Department of Health and Market Hygers importants if flow 27 is marked other the any living or other trearmatic event, the 200s. 9 0 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jennie Curry Peter Ellenberger 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genevieve L. Lear / Sister 1726 Byrd Street, Baltimore Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Oedar Hill Cemetery, January 13, 1999 Baltimore Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 No 3 Probably 4 Unknown Records. à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1□ Yes YNO certificate 1 Yes & No Division of Vitai or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation After X Natural n 24 hours after death.

Funeral Director: Ah bietaly filled in by the fur 1 | Yes 2 | No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Leen January 11, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) olphin street Batto MD2817 MAEEM 501 malun 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 15 Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death January 12,1999 HASTINGS JOHN 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) c. County of Death 7. Age (In yrs. last birthday) H Und Hopkins Saltimore Johns If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 6. Sex 5. Social Security Number Birthplace (State or Foreign Country) Deys 1€ M 2□ F Yrs 215-09-4529 Usual Residence of Decedent Vanuary31,1919 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits U Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 2204 Boston Street 21231 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Never Married 2 ☐ Merried L□Yes 2□ No 1□ Yes 2□ No Specify: White Specify. 3. Widowed 4 □ Divorced Yeer or Detes: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Brick Layer Construction 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) John Hastings Flora Watson 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juliana J. Jones 3317 Putty Hill Avenue Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Balto, Washington Crem. 1/16/99 Laurel, Maryland 22. Name and Address of Facility Dippel FuneralInc. 21. Signeture of Funeral Service Lice 7110 Belair Road Baltimore, Maryland 21206 Approximate Interval Between Onsef and Deeth not enter the mode of dying, such as cardiac or respiratory errest, Immediata Cause (Final disease or condition resulting in deeth) PULMONARY THROMBOEMBULISM TWO DAY RENAL FAILURE ONE PAG Sequentially list conditions, if any, leading to immediata cause. Enter Undarlying Cause (Disease or Injury that Initiated evants resulting in death) Last PRIMARY ONE MONTH METASTATIO CARCINOMA UNKOWN Due to (or as e consequenca of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No FIGRILLATION 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Was an eutopsy performed? OBSTRUCTIVE PILMONARY DISTASE 1 X Yes 1 Yas 20 No 2 No ANTENY. 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

The law requires that the death certificate be exec Box 68760, the 950 P.O. Records, of Vital Division Attending s after death.

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed

Be

MD

**Funeral** 

Director

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21215-0020

Saltimore, Maryland

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Pages 1 and 2 should

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**Physician** 

/Medical

Examiner

Examiner

Physician/Medicai

Medical Certification: To Be Completed by

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL CORONARY 25. Was casa referred to medical examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Lenifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

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29d. Data signed (Month, Dey, Year)

0-13-99

FLOOR BALTIMONE NAMPANO

within 2

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24 hours

State Registrar

L. MARTIN Mn JAN 15 19 31. Date filed /Month. 1999

30. Name and audress of parson who completed causa of daath (Item 23a) (Type, Print)

usti- Mati-

29b. Signeture and title of certifier

South CHARLES (718 2. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2037 JORDAN 1999 · /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 3.5 F If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Min Months Hours 101M 20 F -28-90 Yrs. Director Usual Residence of Decedent 10e State 10b Counts 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director traumatic event, the Medical Examiner must be notifie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Herne 23s Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 8 1 ☐ Yes 2 No Specify Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 117abeth and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Be Knowln as: 10 unknow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) mportant: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 75 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rel 23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or thjury that initiated events resulting in death) Last Records, P.O. Box 68760 99 Physician/Medical signed by the attending d be detached for use as Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Wes an autopsy Completed peed 1 Yes 2 No 1 □ Yes 2 □ No certificate Division of Vital f or Attending Physician: after death. Director: After this certifics 25. Was cese referred to medical Be 26. Place of Death (Check only one) examiner/ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Atterwithin 24 hours after der To the Funeral Director completely filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end dua to the cause(s) and menner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number hud. Jahlay. 13. 1999 100 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

Tensph Sachou Lyb , 8600 Libe Rd. Ballinste

32. Registrar's Signeture

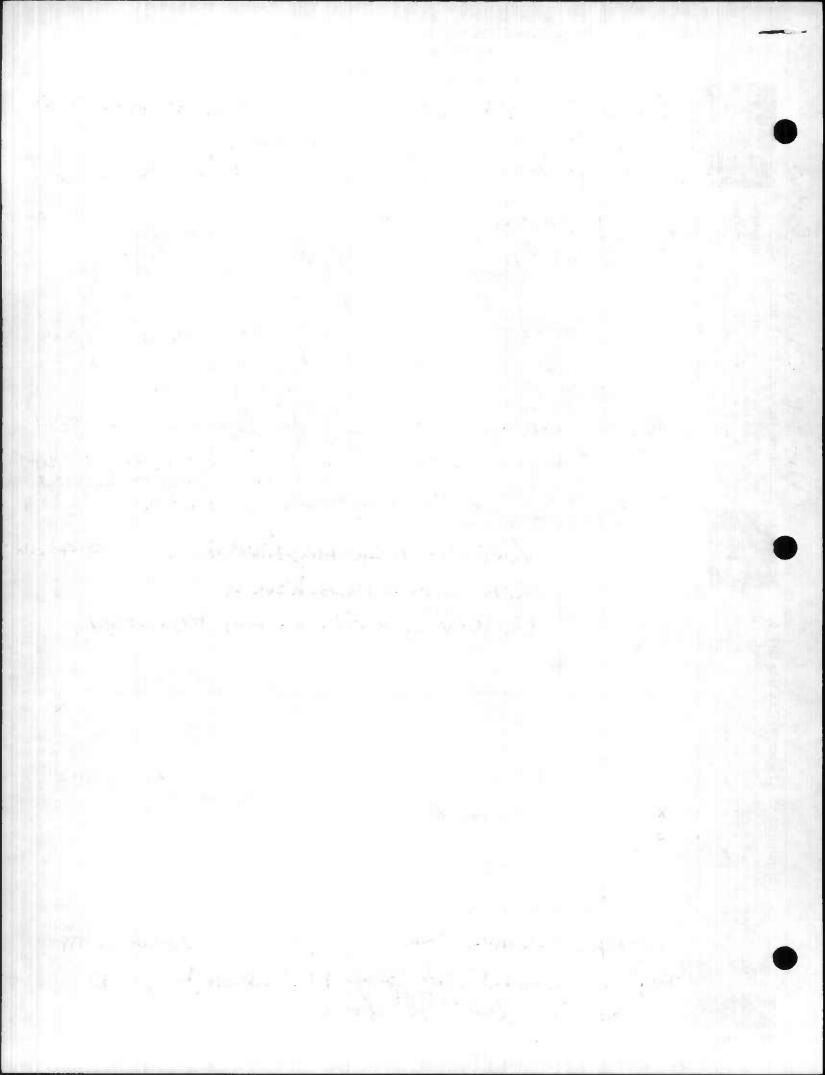
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Registrar

31. Date fited (Month, Day, Year)

JAN 1 5 1999



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**Physician** 

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

7 is marked other than "natural", or itema 23s or 28s-f show traumatic event, the Medical Examiner mant be notified at

12 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural" or Haz

permit. Peges 1 and 2 Department of Heelth e Important: If Item 27 Is any Injury or other trat pncs.

**Physician** 

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Examiner

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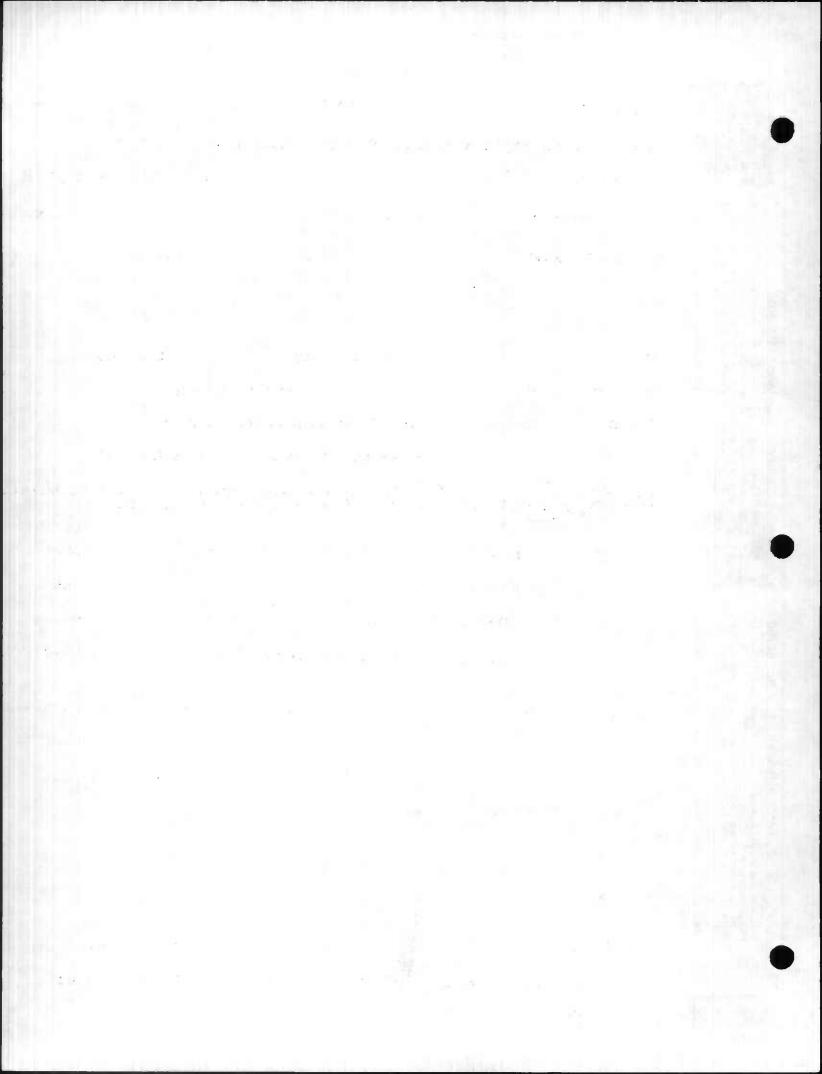
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHNS HOPKINS HOSPITAL 600

NO0 31

JAN 10, 1999

NORTHWOLFE ST BALTIMORE



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2 Data of Death 3 Time of Death Month Day 1999 Yaar John Joseph Jenkins 10 8:40 P.M. Jan. 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Prince George's Hospital Center Cheverly Prince George's Hours Min. 8. Date of Birth (Month, Day, Year) April 15,1925 6. Sex ↑□ M 2□ F If Undar 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign Days Yrs Maryland 215 20 7777 73 Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas YNO Prince George's Maryland Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20784 7014 Freeport Street United States 12. Was Decedent Evar in U.S. Armed Forcas? ½∑¥ves 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Naver Married 2023 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Clara A. Crowl James W. Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Wife 7014 Freeport Street Hyattsville Maryland 20784 Nina P. Jenkins 20b. Place of Disposition (Name of cametery, crematory or other place) Jan. 13, Date 999 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Ramoval from Stata Maryland Veterans Cemetery Cheltenham Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensea 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximata Interval Betwe shock, or heart lailure. Onsat and Death Immediate Cause (Final disaasa or condition resulting in death) Cardio pulmonan Due to or as a consequence(o) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting In death) Last Due to (or as a consequence ol) Part II. Other significant conditions contributing to death and not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy lindings available prior to completion of causa ol death? 24a. Was an autopsy performed? 2 1 No 1 Yas 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yas 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Panding

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Physician /Medical

Examiner

Examiner Physician/Medicai by Completed Be 2 Certification:

**Physician** 

/Medical

Examiner

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**Funeral** 

Director

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permit. Peges 1 and 2 should be filed within 72 hours after death with I Department of Health end Mental Hygiene. Important: If Item 27 Is marked other than "naturel", or Items 29a or any Injury or other traumatic event, the Medical Examinational Examinational Examinations.

Baltimore, Maryland 21215-0020

funeral After

Division of Vital Records, P.O. Box 68760, or Attending Physician: death. ofter death Director:

24 hours e Hospital

To the within 2

Registrar DHMH 16 Rev 6/95

edicai

31. Date liled (Month, Dey, Year)

29b. Signature and title of certifier

2 Accident

4 | Homicide

3 ☐ Suicide

29a. Certifier (Check only one) Investigation

6 Could not be determined

TERRY A. JODRIE, M.D. 32. Registrar's Signature **JAN 1 5** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

29c. Licansa number

D40324

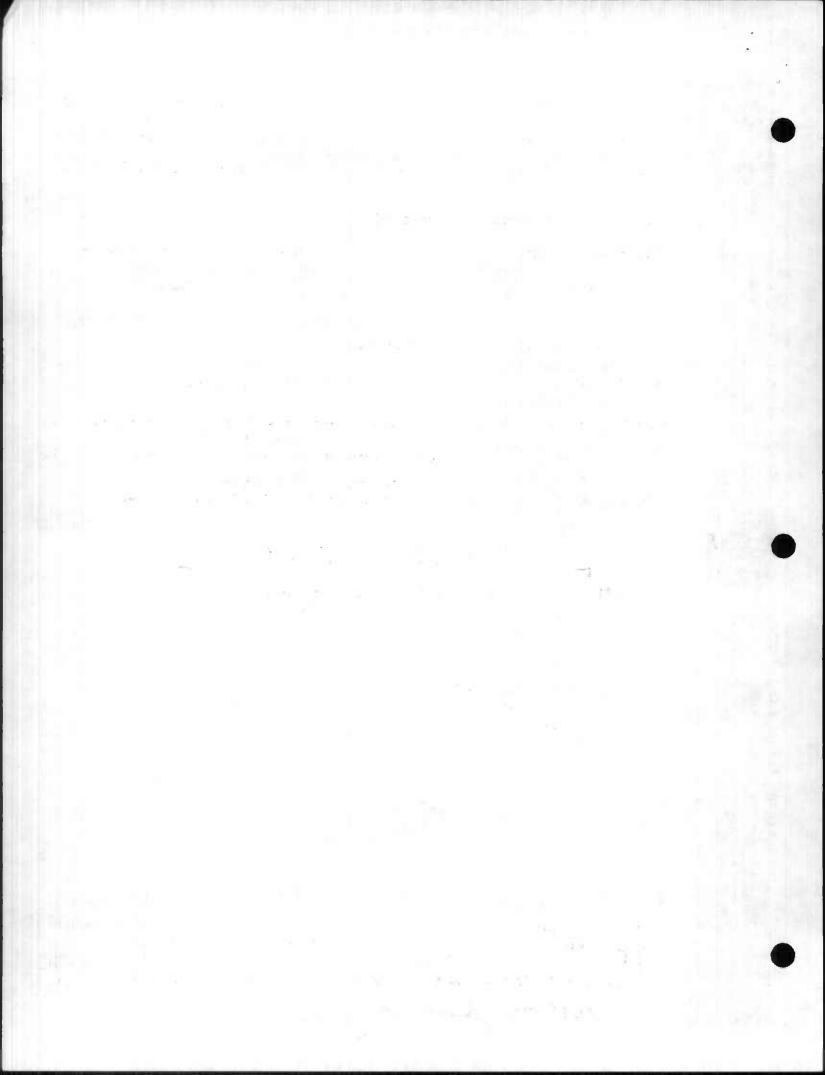
1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Routa Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

3001 HOSPITHL

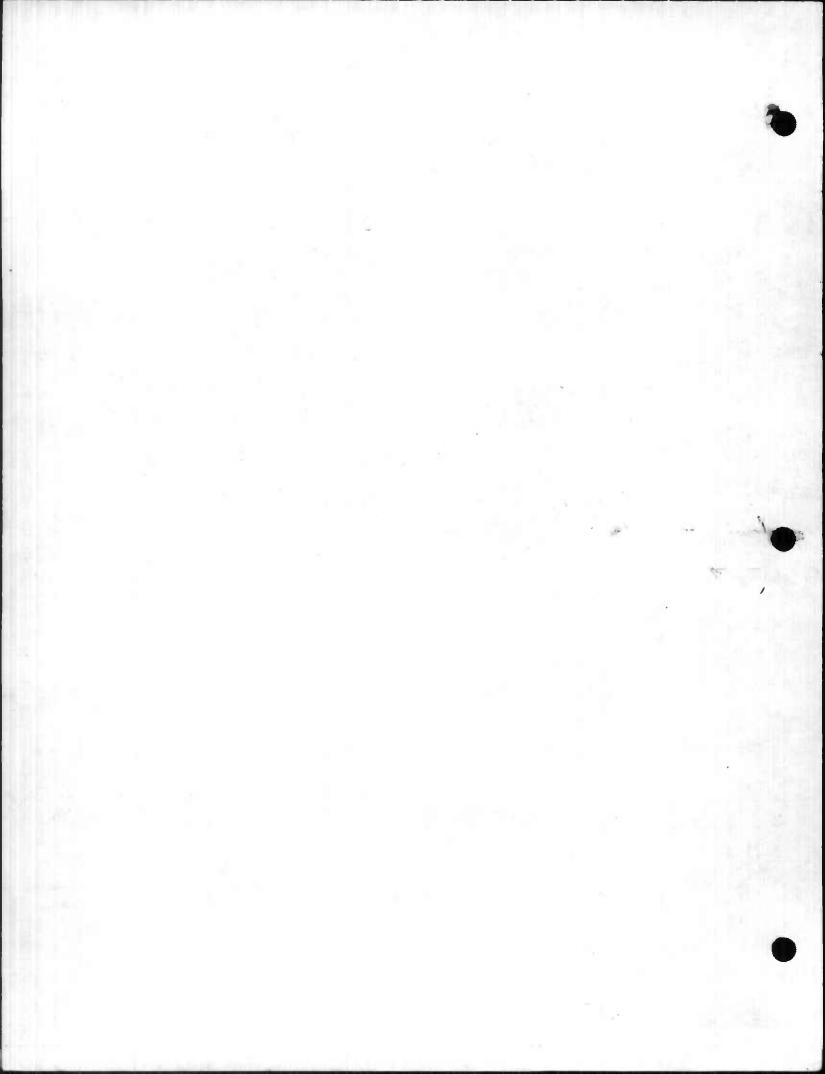
PRINCE GEORGES HOSPITAL CEMER DRIVE, CHEVERLY



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Physician Nathaniel SAMES JANUARY 10 /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore OSPICE 5. Social Security Number If Under 1 Yaar | If Undar 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) 6. Sax 8. Data of Birth (Month, Day **Funeral** 10 M 2 F Days Hours 212-42-4019 Yrs. Director MARYLANG Usual Rasidence of Dacedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Ballimore 1 Yas 2 No Director MARYLAND 10f. Zip Code 10g. Citizen of What Country? USA Collington 21205 Funeral 12. Was Decedent Ever in U,S Armed Forces? 14. Race - Amarican Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Datas: 1□ Yes 2D No Specify: BLACK þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Peges 1 end 2 should be filed within nent of Health end Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HouseKeebing Johns Hopskin Med. 10 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Surnama) Be ester Sones Speak Mant Velen P 19a. Informent's Name/Relationship (Type, Print) David Halling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Balto. Ml. Mandowner 000 N. Patterson 20a. Method of Disposition 20b. Place of Disposition (Nama of Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Ramoval from State nelleky 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Sery 22. Name and Addrass of Facility 1639 ler leu aHo Enter the disease, or complications that caused the death. Do not enter the reart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaase or condition resulting in death) Examiner Physician/Medicai Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequenca of): P.O. Box 68760, Due to (or as a consequanca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Deeth (Check only one) StE //A MARIS AT Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOS DICE 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3□ DOA this 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Da Natural deeth. 1 Yes 2 No 2 Accident after deeth Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 12 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) To the I within 2 29b. Signature and title of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) M JANUARY 30. Neme and address of parson who completed cause of deeth (Item 23a) (Type, Print) BALLIMORE MD 301 S+ PAUL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 20b,c Per FH FilmG767 1-19-99 rja Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1635 ARNOLD A. JENKINS January 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Baltimore 7. Age (In yrs. last birthday)
Yrs. -ospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 1QM 2□ F 81 FEB. 12,1917 214-01-8904 Usual Rasidenca of Decedent VIRGINIA 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MARYLAND N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 11 W. 20TH STREET 2] 2] 8

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: AFRO-AMERICAN 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 10TH TRUCK DRIVER COWAN TRUCKING CO. 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, JACK JENKINS ROSA PAIGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE MATTHEWS 1306 KITMORE ROAD BALTIMORE Co of Disposition (Name of DAUGHTER MD 21239 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Memorial Gardins 20a. Method of Disposition Burial 2 Cremation 3 Removal from State JAN. 18, 1999 ANNE ARUNDEL CO, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the shock, or haart failure. List only one cause on each line: Approximate Interval Batween Onset and Death Immediate Cause (Final disease or condition resulting In death) Intra Vascular Coasulation Dua to (or as a consequence of) sepsis Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Vascular disease Obstruction 1 Tyes 1 Yes 2N No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 1 Yas 25 No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Invastigation 1 Natural 1 □ Yas 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify) 4 ☐ Homicida

**Physician** Examiner Division of Vital Records, To the I within 2

**Physician** 

/Medical

Examiner

**Funeral** 

Director

in than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

2 should be filed within 72 hours after and Mental Hygiena.
Is marked other than "natural", or ite

permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n

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Maryland 21215-0020

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DHMH 16 Rev 6/95

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State Registrar

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29b. Signature and title of certifier

29a. Certifian (Check only one)

> Agner Hospital, 900 Caton Avenue, Baltimore MD. 21230 SI 1999

Doctor

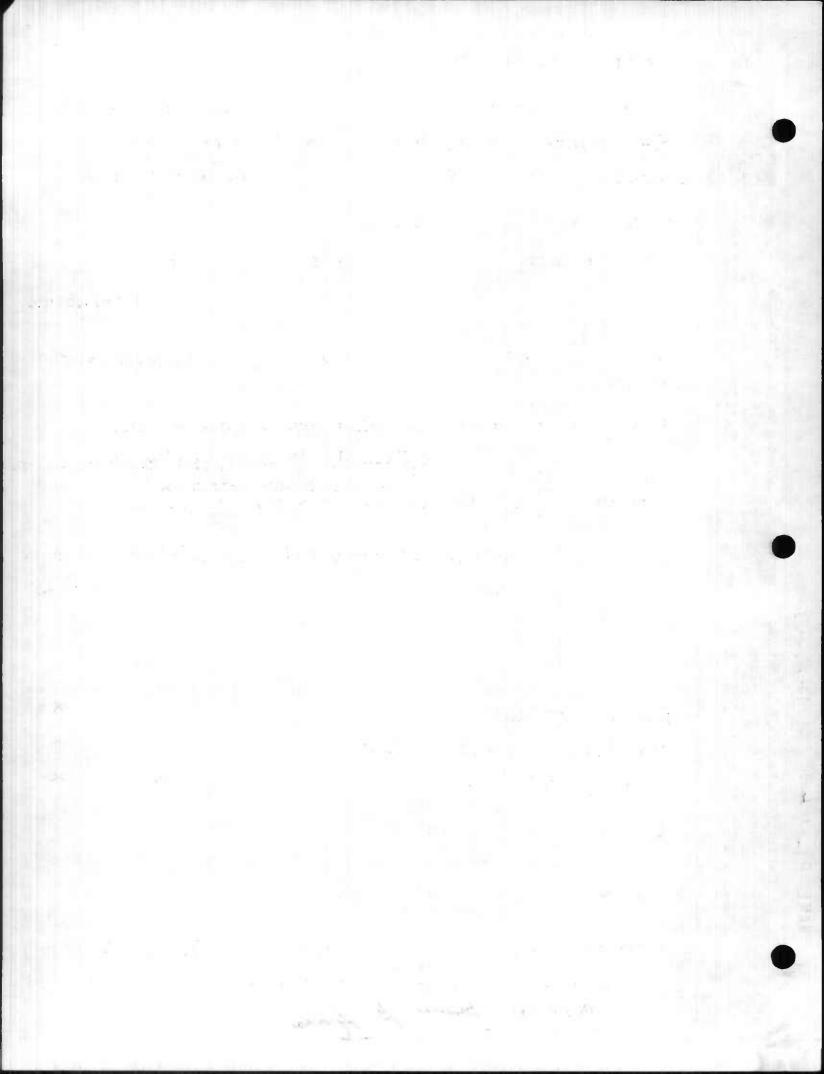
Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

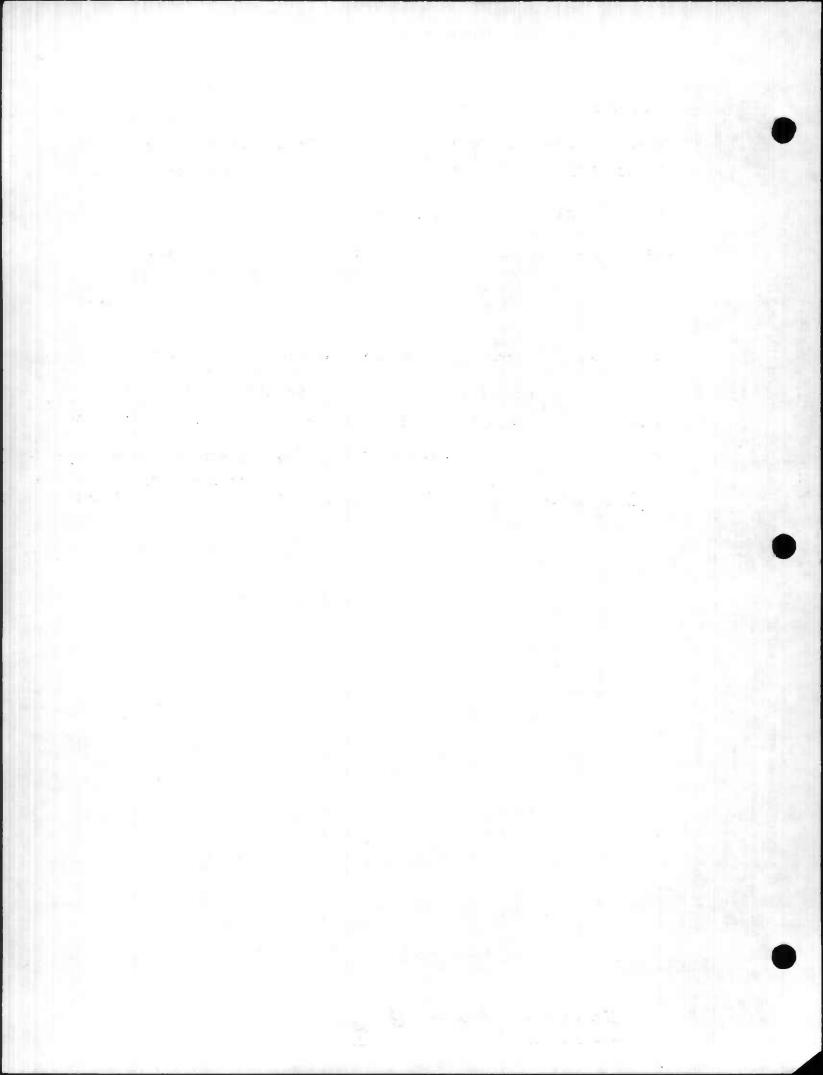
29c. License number



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 0630

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dical	4a Facility Name (If not Institution	give street end number)				4b. City, To	wn, or Lo	cation of Deat		ty of Deeth	9. /	
	Union Memor:	al Hospit	al			Balt	imo	re	NA			
al	5. Sociel Security Number	6. Sex 7. Ag	e (In yrs. last birthda	/) If Under Months	1 Year Days	if Under Hours		8. Date of Bir (Month, De 07-02	th Vest	9. Birtho	piece (Stete or Foreign	
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	Usuel Residence of Decedent  10a. State  10b. County		10c. City, Town or	contion							10d. Inside City Limits	
at', or items 23s or 28s-f show Examiner must be notified at by Funeral Director	MD NA		Baltim								1 ☐ Yes 2 ☐ No	
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<b>Funeral Director</b>	928 Belgian	Avenue		10f. Zip	.218	3		10g. Citizen of What Country USA			ntry?	
eral	11. Marital Status	12. Was Decedent	Ever in U.S. 13				ioin? (Sn	noify Vac or No	14 B	ace - Americ	can Indian	
F	1 Never Married 2 Marri	Armed Forces?	No.			en, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)	Bi	ack, White,		
		If Yes, Give Year or Detes:		1□ Yes 2	2⊠ No	Specify:			Spec	ily: Bla	ack	
20	15. Decedent	s Education	16e. Dec	edent's Usua	i Occup	pation			16b. Kind of	Business/In	duatry	
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To	Frank	Armstro	na			Hat	tie		Riddi	ck		
	19e. tnforment's Name/Relationsh		19b. Me							City or Town, State, Zip Code) 21206		
once. To Be Comp	Joseph	Armstrong	640	6 Bro	ook	Aver	nue	Baltin	more,	Mary.	land	
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	21. Signature of Funeral Service L	icansee		22. Name an	d Addre	ss of Facili	ty Ba	ltimo	re, Ma	ryla	nd 21202	
3	1 June	le luc	2	WM.C.	. Ma	rch I	FH 1	101 E	. Nort	h Av	enue	
	23a. Part. Enter the disease, or a plock, or heart failure. List	proplications that caused	Lthe death. Do not e	nter the mod	e ot dyir	ng, such es	cardiac	or respiretory a	irrest,		Approximate Interval Between	
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tion	1 Netural 5 Pending		(Month, Dey Year) tnjury Work?  M 1 Yes 2 No					28d. Describe how Injury occurred  28t. Location (Street and Number or Rural Route Number,				
completely filled in by the funeral director, page  Medical Certification: To Be Com	3 Suicide 6 Could n	ot be One Disease in in										
ent.	4 Homicide	determined 289. Place of injury - At home, farm, street, tectory, office building, etc. (Specify)						City or Town, State)				
<u>a</u>	29a. Certifier Decertifying	Phyelcten: To the best	ot my knowledge, der	eth occurred	et the tir	me, date en	d plece.	end due to the	ceuse(s) end r	nenner as s	stated.	
Medical Certification:		xaminer: On the basia of end manner ste	examinetion and/or	investigetion,	In my c	pinion, des	th occurr	ed et the time,	dete end place	, end due te	o the cause(s)	
×	29b. Signeture and title of certifier	. )		290	. Licens	se number			29d. Date sign	ed (Month,	Day, Year)	
	100	X	16	14	141	71.413	KK	9260	D1/1	2/00	4	
10	30. Name and address of person v	ho completed cause of 4	eath (item 23e) (Tue		7-11	10-7-	1	1240	01/10	777	21201	
D'	~ .	ANE, MD		. UNI		oc i=v	Das	RKWAY	, RA	Tinant	RE, MD	
State	31. Date tiled (Month, Dey, Year)		ar's Signeture	UNI	VEF	Ollà	1	- NOMY	UPL	TIMOF	(6) 10112	
egistrar	JAN 1 5		under 1	1	,							
	VOIT ( i)	Indiated Section			-							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Kennedy JR. 7:15 A John trancis 01 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street and number) 4c. County of Death Examiner Oak Crest Village 8820 Walther Blvd Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours 11XM 20 F Vrs 176-14-2310 May 5, 1910 Director Pennsylvania Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or Itema 23a or 28a-f ahow the Medical Examiner must be notified at Parkville Yes 2 No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 8820 Walther Blvd Apartment 4417 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. hours after 1 Never Merried 2 Married Specify. White Baitlmore, Maryland 21215-0020 1 Yes ZANo Specify: à 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglane. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Heelth and Mentel thyglan Important: if tem 27 is marked other that eny lojury or other treumatic event, that page. Vice President Bank 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Bialas John F. Kennedy, Sr. 19e. Informent's Neme/Retetionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara K. Yurick Daughter 823 Scarlett Drive, Towson, Maryland 21286 20b. Ptece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial 1/14/99 Cockeysville, Maryland 22. Name end Address of Facility
Burgee-Henss Funeral Home, P.A. 21. Signature of Funeral Service License 21211 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or many fellure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Final AINOMUSKA disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner IDSTAGE ATTUSMED physicien end the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco usa contributa to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown ARTERIOSCUEROTIC CARDIOVASCULAR Records. à 24b. Wera autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed DUSEASE peen page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attanding Physician: within 24 hours after deeth.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1□ Yes ≥ No 2 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Neturat 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number 99

Registrar

**DHMH 16 Rev 6/95** 

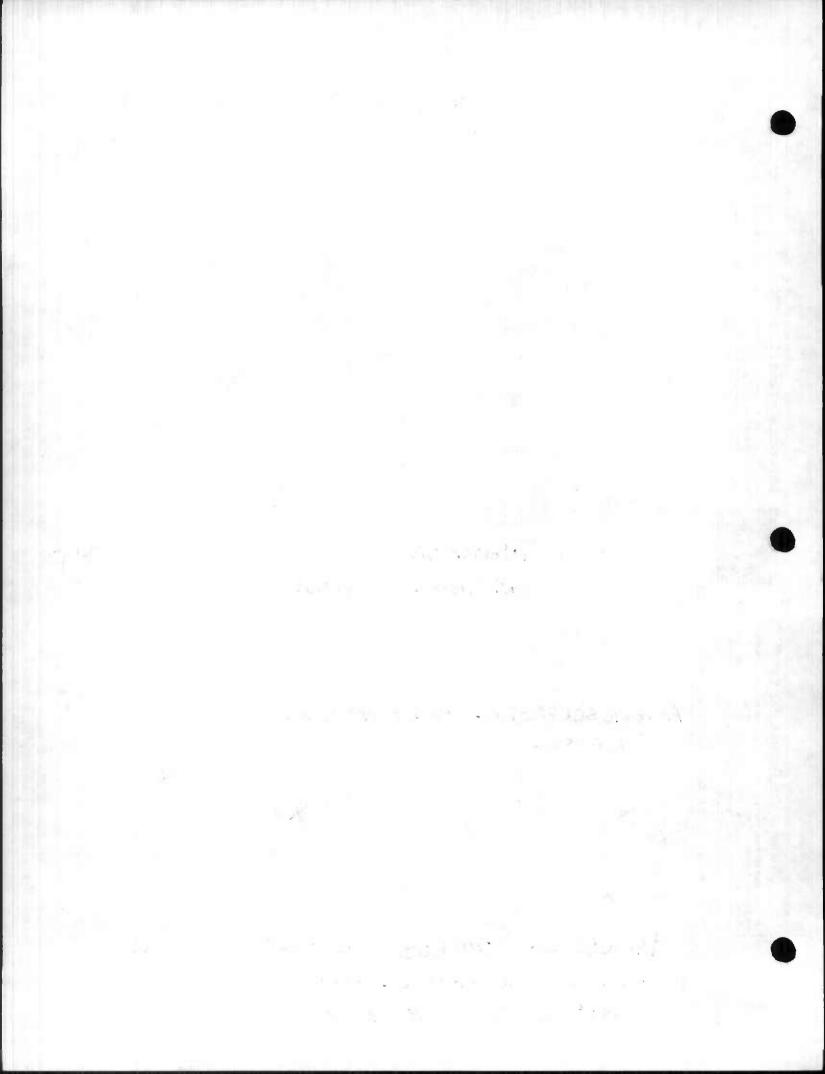
State

31. Date filed (Month, Day, Year) JAN 1 5 1999

Rtauknerms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Oak Creo Villag 32. Registrar's Signeture



dele		1. Decedent's Name (First, Middle, I	99 reb		001	tificate of	Deatii	2. Date o	Reg. No	0.	-	3. Time of Death
siciar edica	n ai	ELEANOR	KNOW					Month	Da	2/	1999	1243pm
xaminer	r	4a. Facility Name (If not institution, s	give street and number					o, or Location of E		. County	of Death	
rai	-	5. Social Security Number 6.	/		last birthday)	If Under 1 Year				ON	9 Righold	aca (State or Foreign
or .		220-44-6632	1□ M 2XF	89	Yrs.	Months Days	Hours	Min. /Month	f Birth J. Day, Year)	909	Mary	(Y) _
9	-	Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Loc	cetion						
		Maryland Baltim	ore		son	Dation					10	od. Inside City Limits  1 ☐ Yes 2 ☑ No
100	0	10e. Street and Number	ore .	TOW	3011	10f. Zip Code			10a. Ch	10g. Citizen of What Country?		
		927 Dunellen Dri	ive			21286				United States		
andrer must	by Funer	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced	If Yes, Give 2	s? No	lf	Vas Decedent of Yes, specify Cut	as Decedent of Hispanic Origin? (Specify Yes o es, specify Cuban, Mexican, Puerto Rican, etc.			es or No- etc.) 14. Raca - American Indian, Black, White, etc.		
1 2	8	15. Decedent's	Year or Date:				pation		16b K	witte		
aplumo	omplet	(Specify only highest g Elementary/Secondary (0-12)	or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)  Homemaker			f working	orking 16b. Kind of Business/ir Own Home			ustry	
event, the Medical I	9	17. Father's Name (First, Middle, La	<b>4</b> st)				18. Mother's	Name (First, Mic				
5	0	George John Bade	er				Ella		Shan	e		
,		19a. Informant's Name/Relationship				g Address (Stree		or Rural Route No			, State, Zip (	Code)
		Douglas P. Knowl 20a. Method of Disposition	les / Son	201		Dunellen skion (Name of	Drive	Towson	-	212		
	1	1 ☐ Burial 2 XCremation 3		to C	cemetery, crem	atory or other pla		1/14/9			- City or Tow	
once.	-	4 □ Conation 5 □ Other (Spec	/	GE		nt Crema		1/14/3	Bal	Ltim	ore, N	Maryland
OUC6		Senne Il	Lander	rak	M	Name and Addr litchell 500 Yorl	-Wiedef	eld Home Baltimo	e, Inc	larv1	and 2	1212
n ai		23a. Part1. Enter the disease or co shock, or heart failure. List only					ing, such as ca	rdiac or respirato	ry arrest,		1	Approximate Interval Between Onset and Death
er		Immediate Cause (Final disease or condition resulting in death)	a. CONG.		E A	HEANT uence of):	FAILL	UNE				54N.
		disease or condition resulting in death)	a. <i>CONG</i> .	Due to (o	A section	uence of):	FAILL	UNE				5 4N.
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Mission Alpha Newaka

21212 15/ 1/10/ 21515

Examiner Box 68760. P.O. F Records, Division of Vital Hospital or Attanding Physician: 24 hours effer deeth. Funeral Director: After this certifica etely filled in by the funeral director, I To the Hospital or within 24 hours eft To the Funeral Di completely filled in

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Norms 23a

death

should be filed within 72 hours effer on Mental Hygiene.
merked other then "natural", or item

permit. Pages 1 end 2 should be to Department of Heelth and Mental Important: If item 27 is merked or

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**Physician** /Medical

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page 2 s

Baltimore, Maryland 21215-0020

Director

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traumetic event, the Medical Examiner must be notified at

Examiner Physician/Medicai Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. þ Completed Be 25. Wes case referred to medical Medical Certification: To 1 Yes 2 No 27. Menne of Deeth 1 Natural 2 Accident 3 Sulcida 4 - Homicide 29a. Certifier t 🖟 cartifying Physician: To tha best of my knowledge, deeth occurred et the time, dete and pleca, and due to the ceuse(s) and menner es steted. 2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

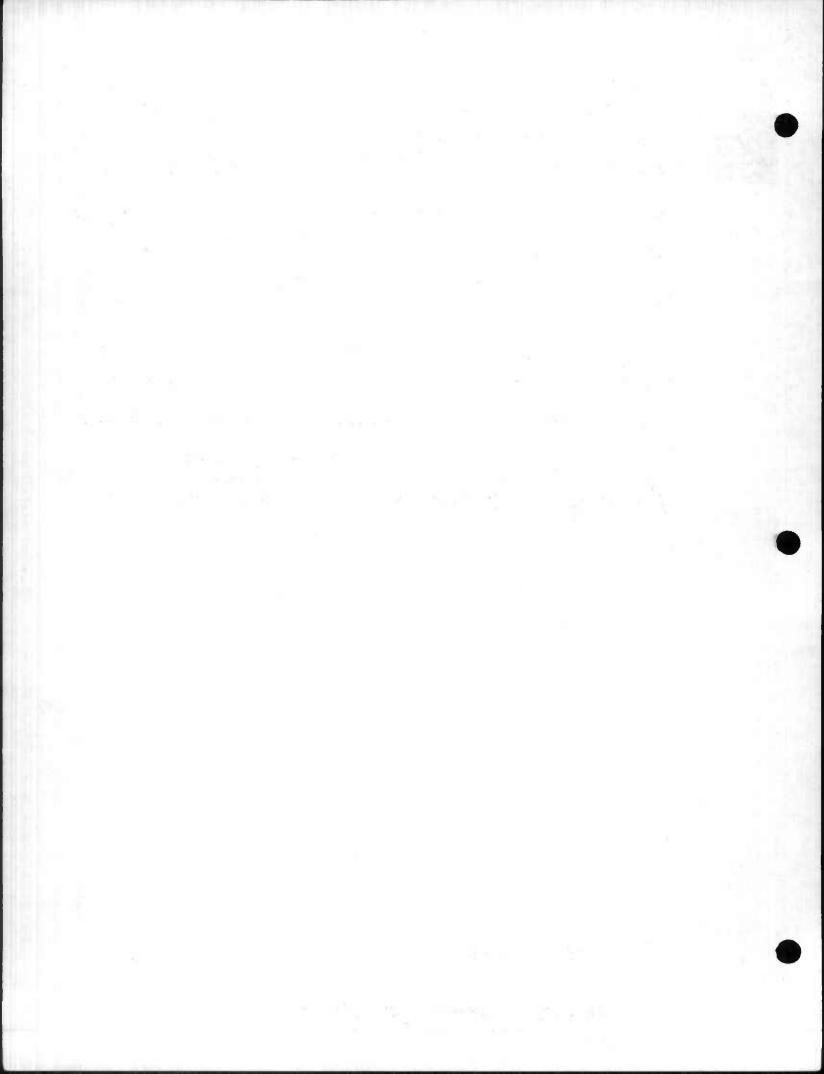
State Registrar

31. Date filed (Month, Dey, Yaar) JAN 1 5 1999

ari uder

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) SR. 2. Dale of Death 3. Tima of Death **Physician** MARC NZIE 12 66 /Medical 4c. County of Deeth Facility Nama (If not institution, giva street and number) or Location of Death Examiner If Under 24 Hrs. 5. Social Security Number MANUARY (Tr. Age (In yrs. last birthday) Birthplaca (State or Poreign Country) Months | 6. Sex 8. Dala of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F Hours Director MARCH 28, 1931 313 -78-0770 MD Usual Residence of Deceda 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 25a-f show 1 PYes 2 □ No Director MD PRINCE GEORGES UPPER MARLBORD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Norns 23s U.S.A. 14. Raca - American Indien, Black, Whita, atc. スロフフン KENFIELD LANE 5716 12. Was Decedent Ever in U,S. Armed Forcas?

1 Yes 2 No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Merital Stetus 1 Nevar Married 2 Merried 1 Yas 2 No Specify: Baltimore, Maryland 21215-0020 'natural', or by 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. "n PLUMBING HEATING Elemantary/Secondary (0-12) College (1-4or 5+) PRESIDENT DWNER AIR CONDITIONING 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Pages 1 and 2 should be fill iment of Health and Mental H tant: If them 27 is marked off Be CHARLES MC KENZIE 0. LILLIAN. REISZ 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) mportant: If itsm 27 any injury or other to 5716 KENFIELD LN, UPPER MARUBORO, MO. 20772 NANCY MCKENZIE JAN 16, 20e. Mathod of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or othar place) 20c. Location - City or Town, Slete 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) ST. JOHN'S LUTHERAN CEN 1999 PARKVILLE, MD 22. Nama and Addrass of Fecility EVANS FUNEEAL CHAPEL 21. Signature of Funaral Sarvice License 23a. Part1. Entar the diseasa, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or haart failura. List only ona cause on eech line. 21234 Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition rasulting in deeth) /Medical ABUTE RESPIRATORY FAILURE Examine Examiner 1-13 no 511 KLMOVARY physician and the buriel-transit certificate be executed Sequentially list conditions, if any, laeding to immediata causa. Entar Underlying Causa (Diseesa or Injury that initialed events rasulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Miknown Records. þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Wes an autopsy performed? The law 2 PNo 1 ☐ Yes 2 ☐ No 1 ☐ Yas Division of Vital Attending Physician: 25. Was case referred to medical axaminer? Be 26. Placa of Death (Check only ona) 1 ☐ Yas 2 ☐ No Other: 4 Nursing Homa 5 Rasidenca 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manger of Death 28b. Tima of 28c. Injury at Work? After 1 Neturel 5 Pending deeth. 1 □ Yas 2 □ No invastigetion 2 Accident 24 hours after deet Puneral Director: 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28a. Pleca of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 filled in Hospital 1 Craifying Physician: To tha best of my knowledge, deeth occurred et the tima, data and place, and dua to the cause(s) end menner es stated. edical 29a. Cartifian To the Hosp within 24 hos To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and plece, and due to the cause(s) and mannar stated. (Check only one) 29b. Signetura and the of certifier 29c. License number 29d. Data signed (Month, Day, Year) Lowett D16849 SUMAHS Rd 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) LARSON KLHNETH JAN 15 1999 32. Registrar's Sjgnatura State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Nema (First, Middle, Last) 3. Time of Deeth Month awrence 10AM 4b. City, Town, or Location of Death 4c. County of Death 4e Faelity Neme (If not institution, give street and number, ORIEN if Under 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) Deys 1 M 2 F Hours 220-07-586 NOV. 26. 1908 Usual Residence of Deceden 10a. Stete 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No 10e. Street and Number 10f. Zlp Coda 10g. Citizen of What Country? 21040 Wes Decedant Evar In U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 12 14. Rece - American Indien 11 Maritel Status Black, White, etc Yes 2 No 1 Never Marriad 2 Merried Specity: White 1 Yes 2 1 No Specify: 3 Widowed 4 □ Divorced Year or Detes: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) nome 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) 19a. Informent's Neme/Reletionship (Type, Pnig) 19b. Malling Address (Street and Number or Rural Route Number, City or Town State, Zip Code) 20b. Plece of Disposition (Name of cometery, cremetory of other plece) Marie Jan 20a. Method of Disposition 20c. Location - City or Town, Stete 18 1 Buriel 2 Cramation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Addrass of Facility 23a. Part 1. Enfer the dissesse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Daath Immediate Ceuse (Final · MYOCARDIAI disease or condition resulting in deeth) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included events.) Due to (or es e consequence of) Dua to (or es e consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evelleble prior to completion of cause of death? 24a. Wes en eutopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Wes case referred to medical 26. Place of Deeth (Check only one) axaminar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28a. Dele of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Netural
2 Accident 5 Pending Investigation

**Physician** /Medicai **Examiner** 

Department of Important: If any Injury or once.

**Physician** 

/Medical

**Examiner** 

**Funeral Director** 

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Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.

Inst: If tem 27 is marked other than "natural", or items 23s or 28s-f show my or other than marked other than the promited and my or other traumatic event, me Mental Estatines man be notified at my or other traumatic event, me Mental as

altimore, Maryland 21215-0020

physician s if the burial

Examir Physician/Medical 6 signed the det Completed page 2 certificate Be 2 8 Certification: After

þ

3 Suicide

29a. Certifie

4 Homicide

(Check only one)

29b. Signature and title of certifier

Division of Vital Records, P.O. Box 68760,

Hospital or Funeral Medical % within 2 To the To the

State Registrar

28e. Place of Injury - Al home, ferm, street, fectory, office building, etc. (Specify)

1 Yas

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

29d. Dete signed (Month, Day, Year)

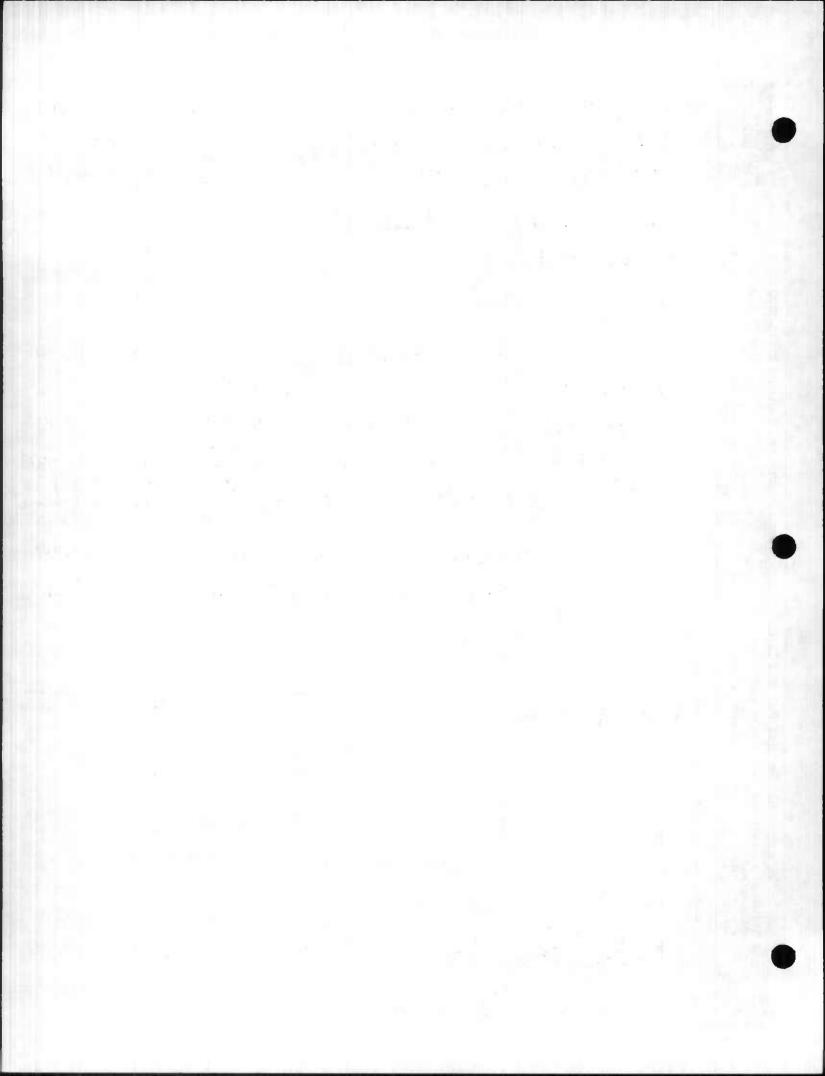
281, Location (Street and Number or Rural Route Number, City or Town, State)

use of deeth (Item 23a) (Type, Print) 1308

31. Dete filed (Month, Dey, Year JAN 15 1999

6 Could not be determined

32. Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 0656 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day Month Year 11:31 AM 1999 January 11 Francis Lerch 4e Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 2802 Liberty Place Prince George Bowie If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Months Hours Devs 1⊠M 2□ F Feb. 12, 1923 PENNSYLVANIA 192-12-7463 Usuel Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 Yes 2 No MARYLAND PRINCE GEORGE BOUIE 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 2802 LIBERTY PLACE 20715 USA 12. Was Decedent Ever in U,S.
Armed Forces?
1 M Yes 2 □ No
If Yes, Give Na VV 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Navy Specify: WHITE 3 Widowed 4 Divorced Year or Detes: 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NASA 12 mathematician 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Neme (First Middle Last) Lerch Charles Helen Monahan 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 2802 Liberty Place Bowie, MD 20715 Margaret Lerch spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/14/99 Glen Burnie, Maryland GLEN HAVEN CEMETERY 22. Name and Address of Facility 21. Signeture of Funeral Surrice Licensee STALLINGS FUNERAL HOME P.A. 3111 Mountain Road Pasadena, Maryland 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heal failure. List only one cause on each line. CONGESTIVE HEART FAILURE

Bue to (or es e consequence of):

Myoearmal INFARCTIONS.

Due to (or as a consequence of): Immediete Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CERTINO MASCULAR ACCIDENT 24b. Were eutopsy findings aveilable prior to 24e. Wes an autopsy performed? completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 28d. Describe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28h Time of 28c. Injury et Work? 5 Pending 1 Natural 1 Tyes 2 No Investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one)

requires that the death certificate be executed The law Division of Vital Physician: al or Attending P s after death. I Director: After I d in by the funer 24 hours after de Funeral Directo letely filled in by th To the Hosp within 24 hot To the Fune completely fi

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, me Wed cal Examiner mant to not the at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or item any Injury or other traumatic event, the Med at Exempted.

**Physician** 

/Medical

Examiner

signed by the attending physician and be detached for use as the bunal-transit

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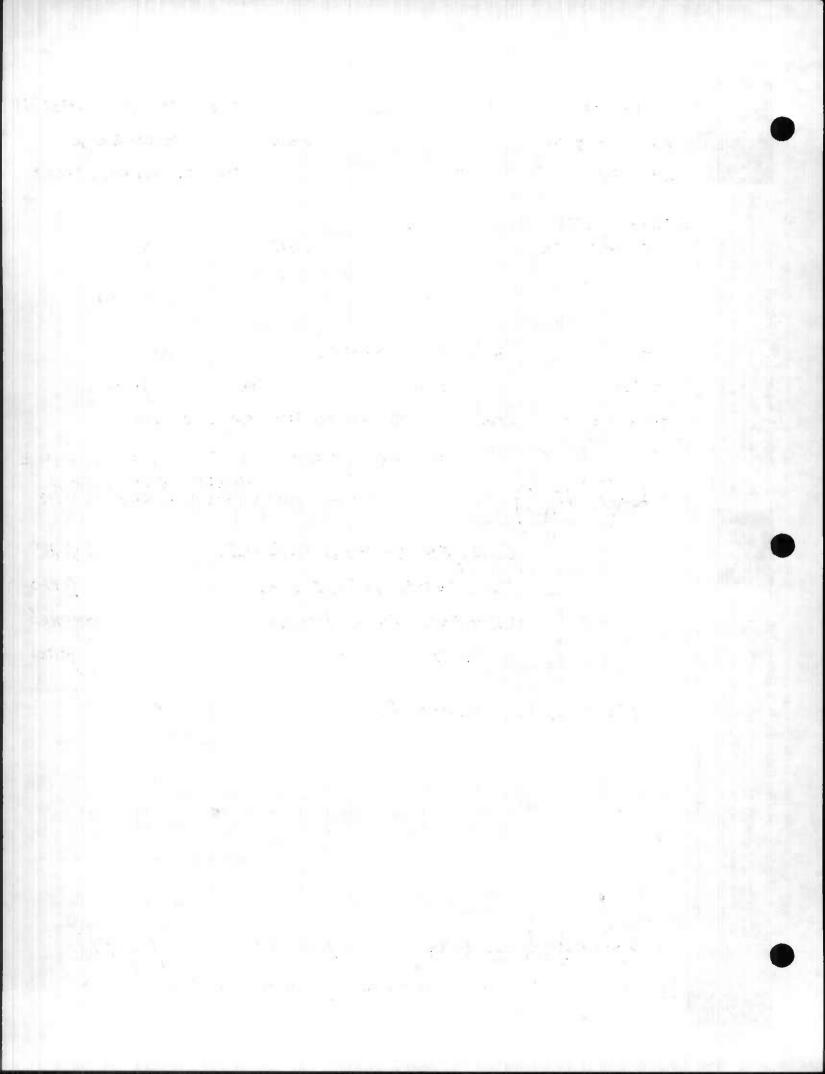
306 Signature and title of certifie

M.D. 32. Registrar's Signature

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

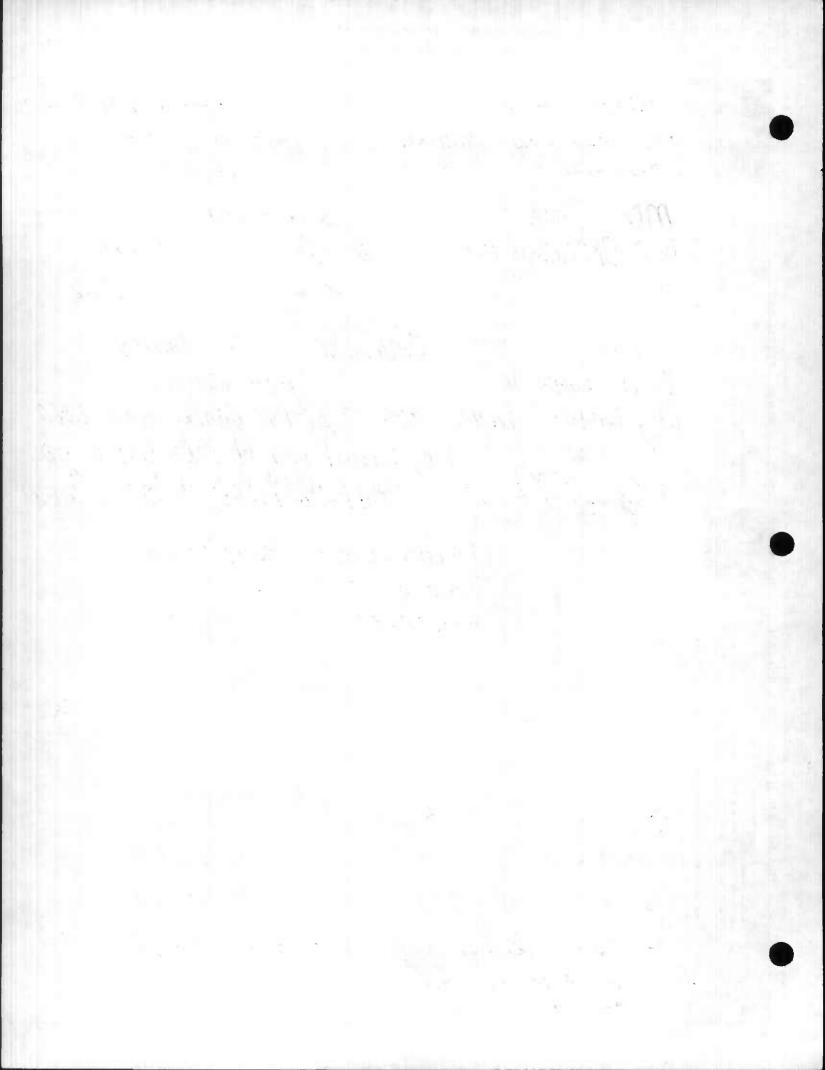
29d. Date signed (Month, Day, Year)

14300 Gallant Fox Lane Suite 122 Bowie, MD 20715



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 163 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Deeth **Physician** 11:25 PM CE ANUATO /Medical 4c. County of Death 4b. City. Town, or Location of Daath 4a Facility Nama (If not institution, giva street and number, **Examiner** SAMARITAL Baltimore MOSPITAL If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax **Funeral** Days Months 7-68-212 12M 20 F Director Usual Rasidence of Dacedani filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Insida City Limits marked other than "natural", or flems 23s or 28s-f show simmile event, the Medical Examiner must be multifald at Baltimord 1 1 Yes 2 □ No Funeral Director NA 109. Street and Number 10g. Citizen of What Country? 10f. Zip Coda 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Ever in U.S. Armed Forcas? Marital Status 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 Yas 2 No Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry bry (0-12) College (1-4or 5+) acto me (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked oth any liqury or other traumatic event ORGs. Be 0 mant's Name/Relationship (Type, Print City or Town, Stete, Zip Code 2/060 altimore, 20b. Place of Disposition (Name b) d of Disposition 20c. Local ion - City or Town, Stata 20a, Met 1 Surial 2 Cremation 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura Funaral Sarvice Cicor Approximeta Intarval Batween Onsat and Death 23a. Part1. Enfer tha disaasa, or complications that causad tha daath. Do not er shock, of heart failura. List only one cause on each line. **Physician** HEART DISCASE /Medical Immediata Causa (Final disaasa or condition resulting in deeth) **Examiner** Dua to (or as a consequanca of) attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Couse (Diseese or injury that initiated avents rasulting in daath) Last Y PERTENSION Physician/Medicai Dua to (or as a consequanca of) 88 signed by the at Id be detached for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably Unknown 1 | Yee 2 | No Division of Vital Records, py 24b. Wara autopsy findings available prior to 24e. Was en autopsy performed? Completed peen complation of cause of death? has 2 No 1 Yas 1 ☐ Yas 2 ☐ No certificata or Attending Physicien: funeral director, 25. Was casa referred to medical agaminar? Be 26. Placa of Death (Check only one) axaminar? 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 8 Other (Specify) OL 1 ☐ Inpatiant 2 ☐ ER/Outpatlent 3 ☐ DOA After this 28e. Dete of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? 5 Pending invastigetion Natural death. 1 ☐ Yas 2 ☐ No 2 Accident 24 hours after death Funeral Director: 3 Sulcida 6 ☐ Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Pleca of Injury - At home, farm, streat, fectory, offica building, atc. (Specify) filled in by 4 Homicida Hospital 1 \*\*Certifying Phyelcian: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated.
2 \*\*Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stated. edicai 29a. Cartifiar completaly (Check only one) within 2 29d. Data signad (Month, Day, Year) 29b. Signature end title of certifian 29c. Licansa number Cathun REP) 30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print) 20874 , M.D MATHEUS 333 Day, Year) 32. Registrar's Signatura State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1999 James Lanno 8:18 PM 4e Fecility Neme (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Bay view Medical Center Baltimore Baltimore Johns Hopkins If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Md Months Dey 1 7944 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) XXX 2□ F 150-34-2774 54 New Jersey Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits MIX Wes 2 No N/A Baltimore Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 U.S.A. 1405 Curie Way 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② (IV) If Yes, Give Year or Dates: 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status XX Never Married 2 Married 1 ☐ Yes X ☐X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fence Repair Home Improvement 11th 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) LNKNOWN Helen Famula 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Weldon Hammonds ( Brother) 1405 Curie Way Baltimore, Maryland 20a. Method of Disposition
1 □ Burial XXX Aremation 3 □ Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Hilltop Service Corp. 1/14/99 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss Funeral Home 21. Signature of Funeral Service License 3631 Falls Road Baltimore, Maryland 21211 3631 Falls Road Baltimore,

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart fallure. List only one cause on each line. Approximate Intervel Between Onset and Death immediate Cause (Final disease or condition resulting in death) · Neuroendocrine Tumor (Metastatic Due to (or es a consequence of): Adult Respiratory Dishers Syndrome 5 days Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Disseminated Intravascular Coaquia him that initiated events resulting in deeth) Last Sepsis 3days 23b. Did tobecco use contribute to the cause of death? Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evallable prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: 1 Hnpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner es steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760 Physician: To the Hospital or Attending Pr within 24 hours efter deeth. To the Funeral Director: After th completely filled in by the funeral

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

**Funeral** 

Director

h end Mental Hygiene. 7 is marked other than "natural", or frems 23s or 28s-f show treumstic event, the Medical Examinet, must be notified at

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Physician

/Medical

Examiner

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Physician/Medical Examine

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Certification:

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with the Marylend

72 hours efter deeth

State Registrar

31. Dete filed (Month, Day, Yeer) JAN 1 5 1999

Cynthia Boyd, mD

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Cyntma Boyd Tower 110 J

29b. Signature and title of cartifier



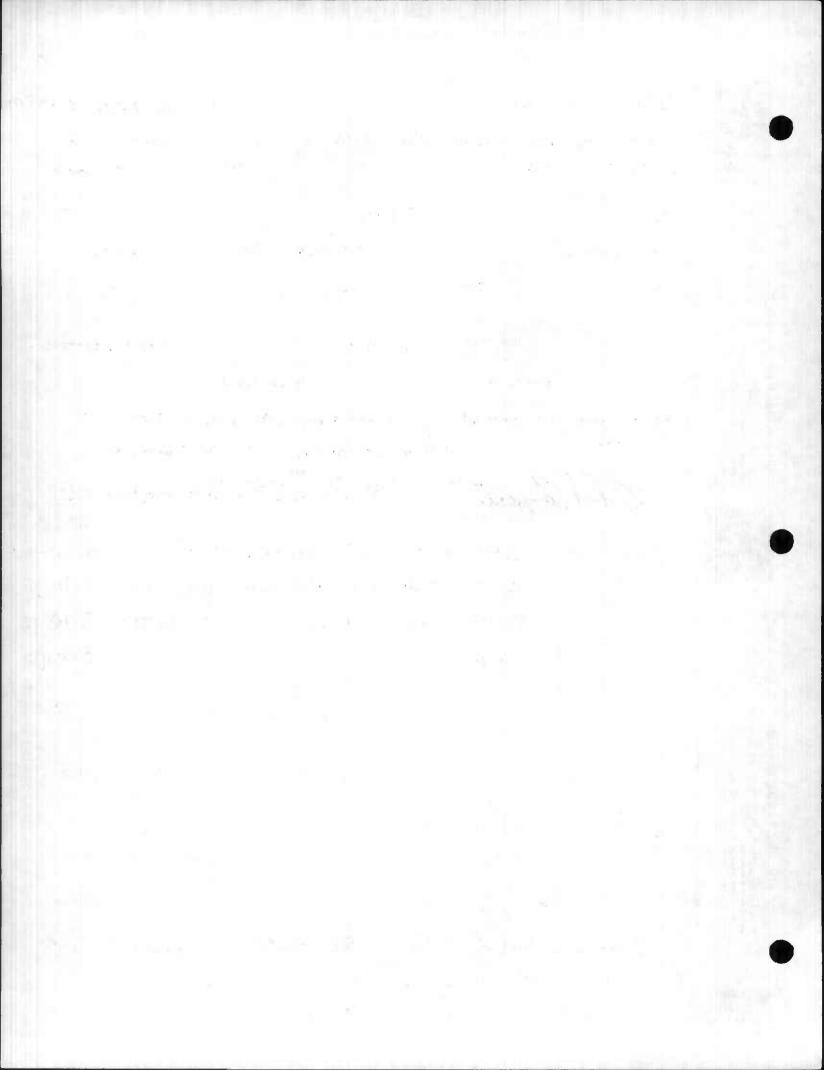
29c. License number

Johns Hopkins Hospital

29d. Date signed (Month, Day, Year)

(January

8,1999



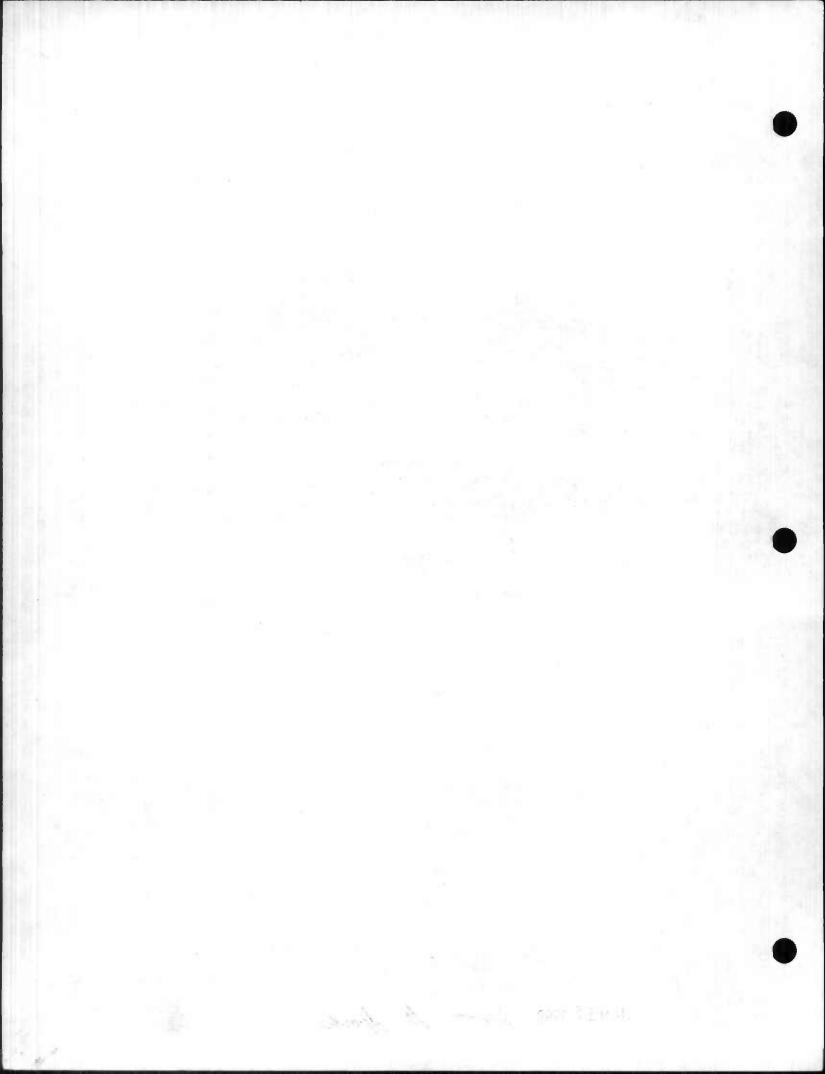
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Syleste L. Larkin Jan. 9, 1999 11:00pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Agnes Nursing Home Howard Ellicott City If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 10M 20F 214-36-9992 88 Yrs. Director Aug. 6, 1910 MD Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits mast be notified at MD N/A Baltimore City Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1414 Belt Street 21230 United States Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Nems 11 Marital Status Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien. Black, White, etc. flied within 72 hours after 1 Yes 37No If Yes, Give Year or Dates: 1 Never Married 2 Merried 21215-0020 1 Yes 2 No Specify: White Specify: py XXWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home i. Pages 1 and 2 should be filed w traint of Health and Mental Hygie tant: If them 27 is marked other ti ijury or other treumatic event, to 8 Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Oliver Mason Barbara Ebert 19a. Intorment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3816 Timber View Way Margaret Zinder / Daughter Reisterstown Maryland 21136 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Paga Department of Important: If eny Injury or paga. 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cem. January 13, 1999 Baltimore Maryland Doda, Jr2, Name and Address of Facility 21. Signature of Funeral Service Licensee Victor P. Charles L. Stevens Funeral Home, Inc. 23a. Partī. Enter the disease, or complications that caused hardshith. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 21230 Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical orsiberazio Examiner Examiner The lew requires that the deeth certificate be executed buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pue Box 68760, Physician/Medical the Due to (or as a consequence of) for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate Attending Physicien: funarai director, 8 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas XX No this 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation Natural To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: At 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifie completely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of contille 29c. License number address of person who completed cause of death (ttern 23a) (Type, Print) 65 EC MD 21043 460 Eucory 31. Date filed (Month, Day, Year) State JAN 15

**DHMH 16 Rev 6/95** 

Registrar



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 2. Date of Death 3 Time of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** Kathryn Denise Long 11:50 A.M. 1999 Jan. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 216 84 2218 1□M ASF 36 Yrs. Director June 30,1962 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Yes 2 No Maryland Prince George's Directo 10a Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2800 Buxmont Lane 20715 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Merital Stetus filed within 72 hours after 1 Never Married XX Merried I ☐ Yes 2 ☐ No If Yes, Give Year or Deles: 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Prince George's Co. Elementary/Secondary (0-12) College (1-4or 5+) School System 12 Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Malcolm Popp Ruth Brooks 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) item 27 i Michael E. Long Husband 2800 Buxmont Lane Bowie Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 9, 1999 20a. Method of Disposition Department of h Important: If ites any injury or oth Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery Silver Spring Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Pert1. Enter the disease, or complication and caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one classification and each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Finat disease or condition resulting in daath) /Medicai Cervical CANCEY 16 month Examiner Due to (or as a consequence of): Examine Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): 81 23b. Did tobecco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Was an autopsy performed? Completed 1 Yes 2 De No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Nother (Specify) Hospice Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how Injury occurred 28c. Injury at Work? 1 Naturat 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be detarmined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, atc. (Spacify) 4 Homicida 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and dua to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and dua to the cause(s) and mannar stated. 29a. Certifies edical (Check only one) within 2 To the i 8 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) UND

ted cause of death (Item 23a) (Type, Print)

6701

32. Registrar's Signature

Charles

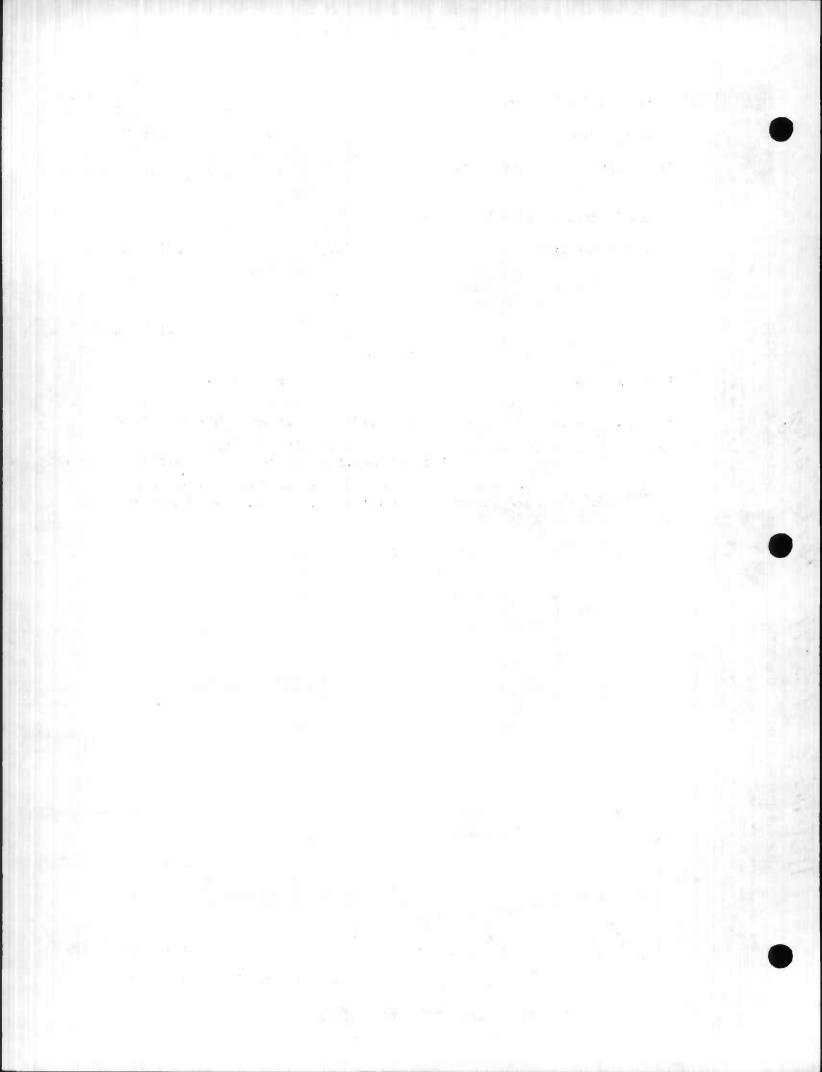
St. Balto md 21204

State Registrar 30. Name and address of parson who die

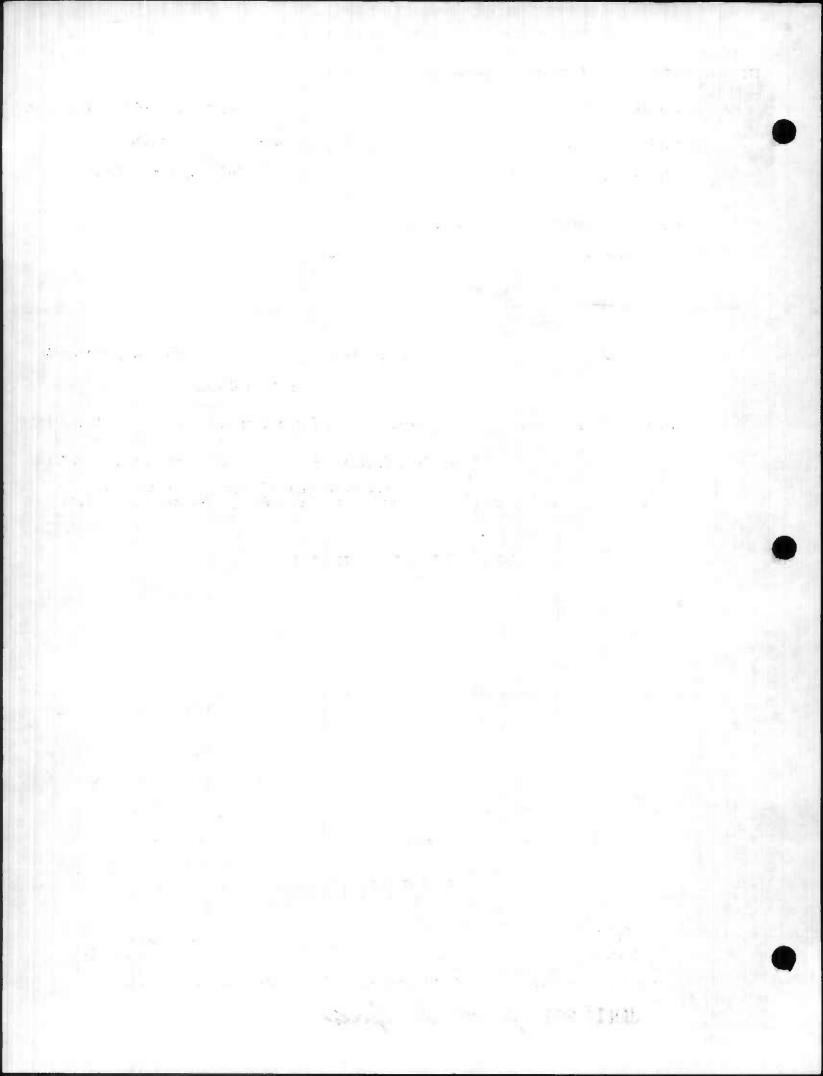
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JAN 15



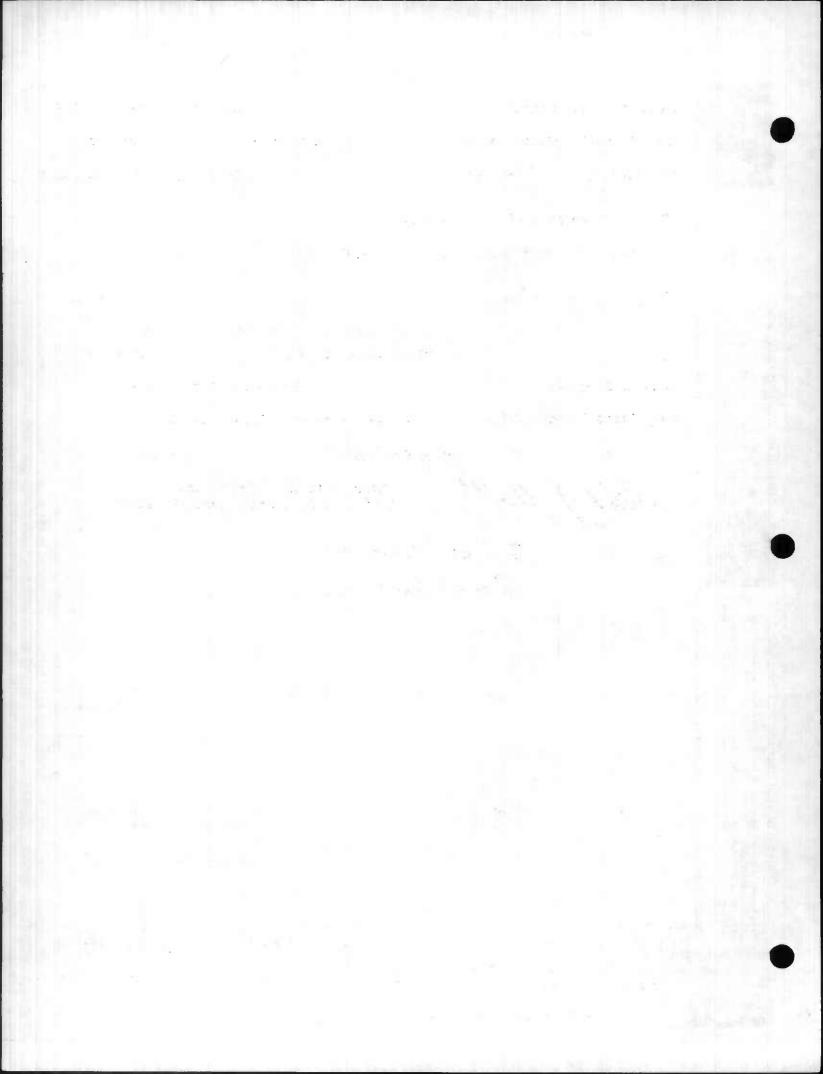
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Dhusisian	1. Decedant's Nama (First, Middla, Las	t)	100	AT AT		2. Date of Death Month		3. Time of Death		
Physician /Medical	LIN LAI LOVE		January							
Examiner	4a Facility Name (If not institution, give	street and number)	4b. City, Town, or	Location of Death	4c. County of	Death				
	5607 Cedar Lane				Columbia		Howard			
Funeral Director	5. Social Sacurity Number 6. Social Sacurity Number 1	9x		If Under 1 Yes Months Day		8. Date of Birth (Month, Day, July 15,	Year) 957	). Birthplace (State or Foreig Country) Chuna		
how	Usuai Residenca of Decedent  10a. State 10b. County	10c. C	ity, Town or Loca	ition				10d. inside City Limits		
the Marylar 28a-f show notified at	Maryland Howard	Col	Lumbia				1 ☐ Yes 2 No			
or 28	10e. Street and Number		•	10	g. Citizan of Wh	at Country?				
th with	5607 Cedar Lane		14		U.S.A.	S.A.				
urs after des	11. Marital Stetus  1 ☐ Never Married 2☑ Married 3 ☐ Widowed ◆※ Bivorcad	12. Was Decedent Ever in the Armed Forcas?  1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? tf Yes, specify Cuban, Mexican, Pu  1 □ Yes 2 No Specify:		pecify Yes or No- to Rican, etc.)		American Indian, White, etc.		
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Hygiene. Hygiene. ther than	12th grade	12th grade Order Puller					y Warehouse			
be tile d othe event, Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, N	laiden Surnama)			
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should not Men marke umatic	19a. Informant's Name/Relationship (7	vne Print)	19h Meiling	Address /Stre			City or Town S	tate. Zin Code)		
d 2 sho th and 7 is m traum	Stanley Cheung (S						per, City or Town, State, Zip Gode) atonsville, MD. 21			
es 1 and of Health I item 27 r other tr	20a. Method of Disposition			9		-		ity or Town, State		
Pag nent int: I	1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	St.	Place of Disposit cometery, crema Paul Lu	uthera	n Cem. 1			n, Maryland		
permit. Departr Imports any Inju	21. Signeture of Funeral Service Licansee  Schimunek Funeral Home of Bel Air, I 610 W. MacPhail Road, Bel Air, MD.									
	23a. Part1. Enter the disease, or comp	ilcations that caused the dea	ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line.							
death certificate be executed e ettending physician and od for use as the buriel-transit	resulting in deeth)  Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b. Dua to (	or as a conseque	ance of):						
\$ 0 a	resulting in death) Last	d								
	Part ii. Other significant conditions co	ntributing to death but not re	sulting In tha und	erlying cause	given in Part I.	23b. Dtd to	bacco use cont	ribute to the cause of deat		
requires that the death cereen signed by the ettendir hould be deteched for use hould by Physician/Reted by Physician/Reted by Physician/Reted by Physician/Reted by Physician/Reted by Physician/Reted by Physician/Reted						1 □ Yı	s 2□ No 3	Probably 4 Unkno		
aw requir						24a. Wes er perform		24b. Were autopsy findings available prior to completion of cause of death?		
The page						1 ☑ Ye	s 2 No	1 ☐ Yes 2 ☐ No		
certificate rector, pag	25. Was case referred to medical				26. Place of De	ath (Check only on	9)			
Physician: this certific ral director,	examiner? 1 ☑ Yes 2 ☐ No	Hospital:	ER/Outpatient	3□ DOA	Othor			(Specify)		
or this eral di	27. Manner of Death	28a. Date of injury	28b. Time of tnjury	28c. lr	njury at Vork?	Home 5 X Residenca 6 ☐ Other (Specify)  28d. Describe how Injury occurred				
ding After fundition	1 □ Netural 3 □ Pending investigation	Found: 1-6-99		Vork? ☐ Yes 2 🕅 No	SUBJECT INGESTED DRUGS		RUGS			
To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	3 Suicida 6 Could not be 4 Homicide determined	C8	281. Location (Street and Number or Rural Route Nu City or Town, State) 5607 CEDAR LANE							
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omple of the	29b, Signature and stig of certifier			29c. Lice	ense number	25	d. Date signed	(Month, Day, Year)		
F \$ F 0	+ Gland For	5. Rudents			.M.E.	R	e-Issued anuary b	d		
	30. Name and address of person who of Stephen S. Raden				Baltimore,	Marylan	d 2120			
State Registrar	31. Date filed (Month, Day, Year)	32. Registrer's Sign	eture	lone	,					



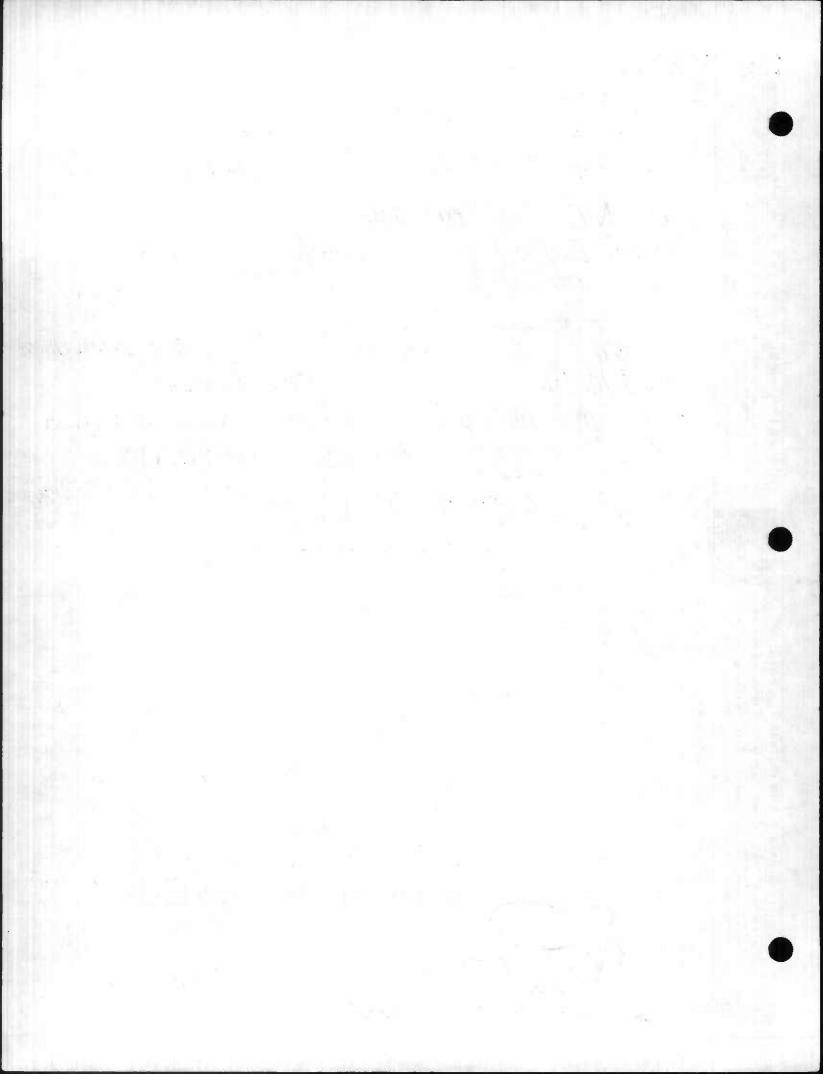
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		Anne Arundel Medical Center  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under						Miller deed 3		Annapoli			nne 1					
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	2	MD Anne Arundel Annapolis										^						
2 3	Director	10e. Street and Number 701 Glenwood Street Apt. 21						10f. Zip Code					itizen of V	Vhat Coun	itry?			
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DHMH 16 Ray 6/95



99-0126-510 jhm	Please T	ype or Print in Blac					e.
LAWRENCE THE	ODORE S: #23 PART I, 27,	State of Maryland / [	Certificate of	Death		g. No.	00643
Physician	1. Decedent's Name (First, Middle, Last)	F. T. MIL	LER SI	2.	2. Data of Deat Month JANUARY	h	3. Time of Death 9 00:15 AM
/Medical Examiner	4a Facility Name (If not institution, give s 423 NORTH ELLWOO			4b. City, Town, or I		4c. County of I	Death
Funeral	5. Social Security Number 6. Sex		thday) If Under 1 Year			9.	Birthplace (State or Foreign
Director	Usual Rasidence of Decedent	100	Yrs. Months Days	Hours Min.	Devember	18, 1956 M	ary/and
2 2	10a. Stete 10b. County 10e. Street and Number	Ba Town	10f. Zip Code			og. Citizen of Wha	10d. Inside City Limits 1 1 Yes 2 No
death with the	423 N. Ellwo	od Ave.	2/20	34		U.S. F	9.
020 urs after M', or its by Fu	11. Marital Status  1 Naver Merried 2 Married 3 Widowed 4 Divorced	2. Was Decedent Evar in U.S. Armed Forces?/ 1	13. Wes Decedent of lif Yes, specify Cub  1 ☐ Yes 2 ☐ No		pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No-		American Indian, White, etc. BIACK
21215- d within 72 piene. nat r than 'nat	15. Decedent's Educ (Specify only highast grade Elemantery/Secondary (0-12)	ation completed)  College (1-4or 5+)	Decedent's Usual Occul (Give kind of work done life. DO NOT use retire	during most of wor	king	Home I	mprovement
Maryland 2 d 2 should be filled th end Mental Hygi T is marked other traumatic avent,	17. Fether's Name (First, Middle, Last) DRVID MILLER			18 Mother's Nam MARY	na (First, Middle, A PNULL)	faiden Sumame)	
CENL	19a. Informant's Name/Relationship (Tyr. Arlette M. G.	Miller-Wife 4	Mailing Address (Street	WOOD AV	Bal.	o, mi	21224
0 82 = 8	20a. Method of Disposition  1 Buriel 2 Cramation 3 Re 4 Donation 5 Other (Specify)	emovel from State  King	Disposition (Name of y, crematory or other pla	ark il	15-99 K	and als	Wn, MD
Baitim permit. Per Department Important: any injury parte.	21. Signature of Funerel Service License	1	22. Nama and Address  27) Front	hiltin A	ary Ba	march	mi 2/201
	23e. Part1. Enter the disease, or complice shock, or heart failure. List only on	setions that caused the death. Do re cause on each line.	not enter the mode of dyi	ing, such as cardiac	or respiratory arm	est,	Approximata Intervel Between
Examiner	Immediate Cause (Finel disease or condition resulting in death)	2011 - 1016	D NARCOTIC	INTOXICAT	ION		Onset and Death
8 01 X	Sequentially list conditions, if any, leading to immediate	Dua to (or as a	consequence of):				
6876( filcate be physicia as the bur ledical	cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in deeth) Last	Due to (or es a c	consequence of):				
death cert death cert death cert set for use	Pert II. Other aignificant conditions cont	ributing to death but not resulting in	the underlying cause of	iven in Part I	22b Did to	hacco usa contri	buts to the cause of death?
	Total Survey and an extenditions con	induing to death but not resulting if	Tille underlying causa gr	VOIT HT F CITT.			Probably 4 Unknown
Cord requir been s should					24a. Wes a perform		4b. Were autopsy findings available prior to completion of cause of death?
				200	typ ve	s 2 No	1 <b>75</b> Yes 2□ No
V Pick C	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	ospitel: 1 Inpatient 2 ER/Ou	tpatient 3 DOA		ome Star Reside		(Specify)
on of alling Phys After this funeral d	27. Menner of Death 1 ☐ Neturel 5 ☐ Panding	28a. Data of Injury 28b. 1	ime of _ 28c. Inju	ork?		w injury occurred	
Division or Attending after death. Director: After d in by the tune ertification	2 ☐ Accident invastigation 3 ☐ Suicide 6 ☒ Could not be	1-3-99	1:45	Yes 2 (3) No	UNKNO		or Rural Boute Number
Division o To the Hospital or Attending Ph within 24 hours affect death. Completely filled in by the tuneral Medical Certification:	4 Homicide detarmined  29a. Certifier 1 Certifying Physics	28a. Place of tnjury - At home, fe building, etc. (Specify) FOUND: HOME clan: To the best of my knowledge			AVE. BA	LTIMORE	or Aural Route Number NORTH ELLWOOD CITY, MARYLAND
To the Hospital within 24 hours To the Funeral completely filled Medical Co		or: On the basis of axamination and					
Toth within Toth comp	29b. Signature and tive of certifier		29c. Licen	se number		9d. Data signed (/	
		200	OCM	E		JANUARY	09, 1999
	30. Neme and address person who cor	npleted bausa of death (Item 23a) (	Type, Print)  1 Penn Stre	et, Balti	more, Ma	ryland 2	1201
State Registrar	31. Dete filed (Month, bax, Year) JAN 1 5 1999	32. Registrar's Signature	house				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death

JANUARY 8, 1999

DRADFURD MURGAN		Ce	runcate of	Dealli		Reg. No.	
1. Decedent's Name (First, Middle, La Barbara Bradford					2. Date of D JANUAI		3. Time of Dec
4a Facility Name (If not institution, give	re street and number)			4b. City, Town	n, or Location of Dea	th 4c. County of	of Death
100 Rock Lane				Stever	nsville,MI	Ann	e-Arundel
,		(In yrs. last birthday) 6 Yrs.	Months Days		Hrs. 8. Date of B (Month, D May 4		Birthplace (State or Fo Country)     LA
Usuai Residence of Decedent						, =====	
10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Li
	nne-Arundel	. Sev	erna Par	k, Mary	/land		1 □ Yas 25
10e. Street and Number 477 Fairoak Drive	9		10f. Zip Code	2114	16	10g. Citizen of W United	hat Country? States
11. Marital Status  12. Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedeni E Armed Forces? 1 Yes 2000 If Yes, Give	0	Was Decedent of If Yes, specify Cut		n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race Biack Specify:	- American Indian, r, White, etc. White
	Year or Dates:	160 Page	dentie Heuri Oneu	nation		10h Kind of Day	
15. Decedent's E (Specify only highest gre		/Give	dent's Usual Occu kind of work done DO NOT use retire	during most o	of working	16b. Kind of Bus	siness/industry
Elemeniary/Secondary (0-12)	College (1-4or 5-	+)					High School
17. Father's Name (First, Middle, Last	)		Stu	18. Mother's	s Name (First, Middle	, Maiden Sumeme	)
Walter Truett Mo					eline M. T		
19a. Informant's Name/Relationship (		19h Maili	na Address /Stree		or Rural Route Numi		
Walter Truett Mon							
20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other pla	ace)	Date	20c. Location - 0	City or Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif					m   Jan 11, 1	999 Ra	leigh, NC
21. Signeture of Funeral Service Licer  23a. Part1. Enter the disease, or com shock, or heart failure. List only	Jash	1	501 E. F	ort Ave	ens Funera enue, Balt ardiac or respiratory	imore Ma	ryland 2123  Approximate Interval Between Onset and Deat
Immediate Cause (Final disease or condition resulting in death)	a	Droun	ns				Crisei and Deal
		Due to (or as a consec	quenceror):				
	b	ue to (or es a consec					
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury		oue to (or es a consec	querice ory.				
Cause (Disease or Injury that initiated events	c	ue to (or as a consec	wonen aft.				
resulting in death) Last	·	de to (or as a consec	quence or):				
	d					4 3 5	
Death Other death and district					1 201 21		1
Part II. Other significant conditions of	ontributing to death but	not resulting in the u	indenying cause gi	ven in Part I.		1	tributa to the cause of de 3 Probably 4 Unit
						s an autopsy ormed?	24b. Were eutopsy finding available prior to completion of causof death?
					15	Yes 2□No	1 Nes 2 No
25. Wes case referred to medical			10.19	26. Place o	of Death (Check only	one)	
examiner? XX Yes 2 □ No	Hospital:	t 2 ER/Outpatier	nt 3 DOA	hor	sing Home 5 Res		(Specify) AT SC
27. Menner of Death 1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Manth, Cay	Year) 28b. Time o	Wo	ry at ork? Yes 2 N	Testo a	how injury occurred	
3 Suicide 6 ☐ Could not be determined	e 28e. Place of Injur building, etc.	At home, farm, str (specify)	reet, factory, office		28f. Location City of To	(Street and Number	er or Rural Route Number,
	ysician: To the best of niner: On the basis of a and manner state	examination and/or in					
29b. Signature and title of certifier	1		29c. Licen	se number		29d. Date signed	(Month, Dey, Year)

State Registrar

31. Date liled (Month, Dey, Year)

person who completed cause oi death (Item 23a) (Type, Print)

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

OCME

**DHMH 16 Rev 6/95** 

/Medical Examiner

To the Mospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affard death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

99-0192-51 JAMES	O Pleas	e Type or Print in E State of Marylan			•	200 0001 5
McNEILL			•	nte of Death	Reg. N	22 00040
Physiciar /Medica	1/1/1/2 1/1/2	illie Mc	Neill		JANUARY 1	3. Time of Death 12, 1.999 4:45P.M.
Examine	4a Facility Name (If not institution, g 1236 ELMLEAF COU			4b. City, Town, or BALTIMO		c. County of Death
Funeral	5. Social Security Number 6	Sex 7. Age (In yrs.	last birthday) If Unc	ler 1 Year   If Under 24 Hr	s. 8. Date of Birth	9. Birthplace (State or Foreign Country)
Director	912 - 46 - 6929 Usual Residence of Decedent	102M 2DF 52	Yrs.	o Days Trous	12-3-4	16 North Carolin
after death with the Manyland or items 23e or 28e-f show cine mest be notified at	10a. Stete 10b. County	V/A Bo	y. Town or Location	8		10d. Inside City Limits
with the or 2	10e. Street and Number	20 E D O+	101.2	Tip Code	10g. C	citizen of What Country?
free death v	1300 [ ]VIL	12. Wes Decedent Eventry	S. 13. Was Dec	pedent of Hispanic Origin? ( pecify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,
or he		If Yes, Give	if Yes, sp	2 2 No Specify:	rto Hican, etc.)	Black, White, etc.  Specify: 2
72 hours at natural, or		Year or Detes:	16a. Decedent's Us		orting U.W. 16b.	Kind of Business/Industry
2121 3 within piene.	(Specify only highest of Elementery/Secondary (0-12)	College (1-4or 5+)	(Give kind of a	vork done during most of w	orking VIVO.	under state of the
yiand build be fill Mental H Mental H mrked off	17. Father's Name (First, Middle, La Harvey M	Neill SR.		Bed Sed	elia N	1 Callum
Mag d 2 s y 1 is trau	19a Informent's Neme/Relationship	(Type, Print)	19b. Mailing Addre	ss (Street and Number or F	Pural Route Number, City  Ver C+	or Town, State, Zip Code)  • 2123 (
O - 2 E E	20e. Methyd of Disposition	_	lece of Disposition (A	lame of rother place)		Location - City or Town, Stete
0 5 = 5	1 Danetion 5 Other (Spec	Memovel from Stete	oschel	l .	1/16/9 Ba	Himore, Marykux
Baltim	21. Signeture of Eureral Service No.	yrsea	22. Name	and Address of Facility	639 Nort	h Broadway
_ 40240	23a Party Edwine disease or or	mplications that caused the death	Jec	Willer		nome + Services
Physician	23a Party Editor he disease, or co	y one ceuse on each line.	. Do not onto the in			Interval Between Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Aiswen	aru atto	nesclarche	Carlions	celar Disease
		Due to (o	ras a consequence o			
and transit	Sequentially list conditions,	Due to (o	r es a consequence o	7):		
O S C T	if any, leeding to immediate cause. Enter Underlying					
certificate be axed and refine physician a use as the burial-land.	that initiated events resulting in deeth) Lest	Due to (or				
Box 6 eath certification of the seath certification of the seath certification of the seath of t		I d				
. 0 00 2	Part II. Other eignificant conditions	contributing to death but not resu	ulting in the underlying	cause given in Pert I.	23b. Did tobacc	co use contribute to the cause of death?
		alcoholism			1 Tes	2 No 3 Probably Cunknown
cords requires been sign should be					24a. Wes an autoperformed?	
					₩ Yes	2 No 12 Ves 2 No
Vital Insident Thront Certificate irector, page Co	25. Was case referred to medical examiner?				sath (Check only one)	
To To	199.100	Hospitel: 1 Inpatient 2	ER/Outpatient 3 28b. Time of		Home 5% Residence 28d. Describe how inj	
Vision Attending B ordor: After by the funer Hiscation:	1/2 Naturel 5 Pending	28a. Dete of Injury (Month, Day Year)	Injury	28c. Injury at Work? 1 Yes 2 No	Loc. Book to the	ary occurred
- x25c	3 Suicide 6 Could not determine	be d 28e. Place of Injury - At ho building, etc. (Specify		Dry, office	28f. Location (Street a City or Town, Ste	and Number or Rural Route Number, ite)
o the Hospital of thin 24 hours at o the Funeral Dompletely filled i	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exp	Physician: To the best of my known miner: On the basis of examinet and menner steted.				(s) and manner as stated. nd place, and due to the cause(s)
A STATE OF	29b. Signeture end title of certifier	0.0	12	9c. License number	29d. D	Pate signed (Month, Day, Year)

To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After t completely filled in by the funeral

State Registrar

29b. Signeture end title of certifier hurte us 29c. License number

O.C.M.E.

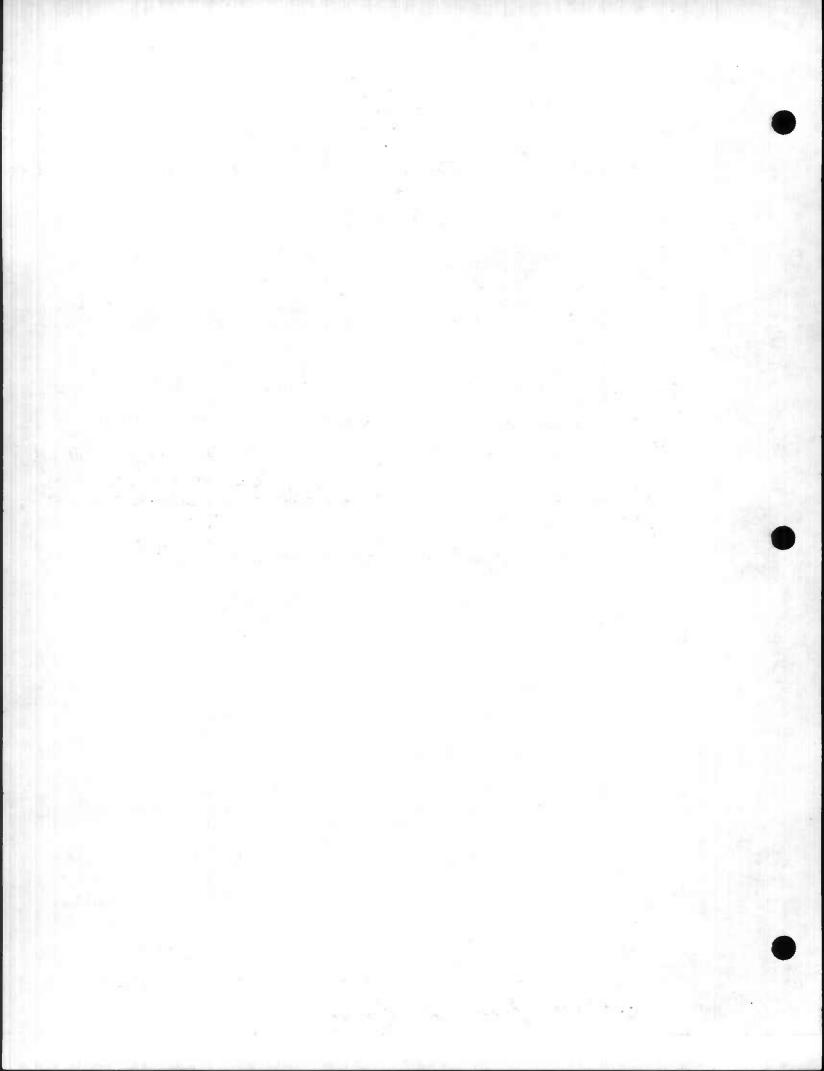
JANUARY 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute M)

111 Penn Street, Baltimore, Maryland 21201

31. Date liled (Month, Dev. Year) 22. Registrer's Signature

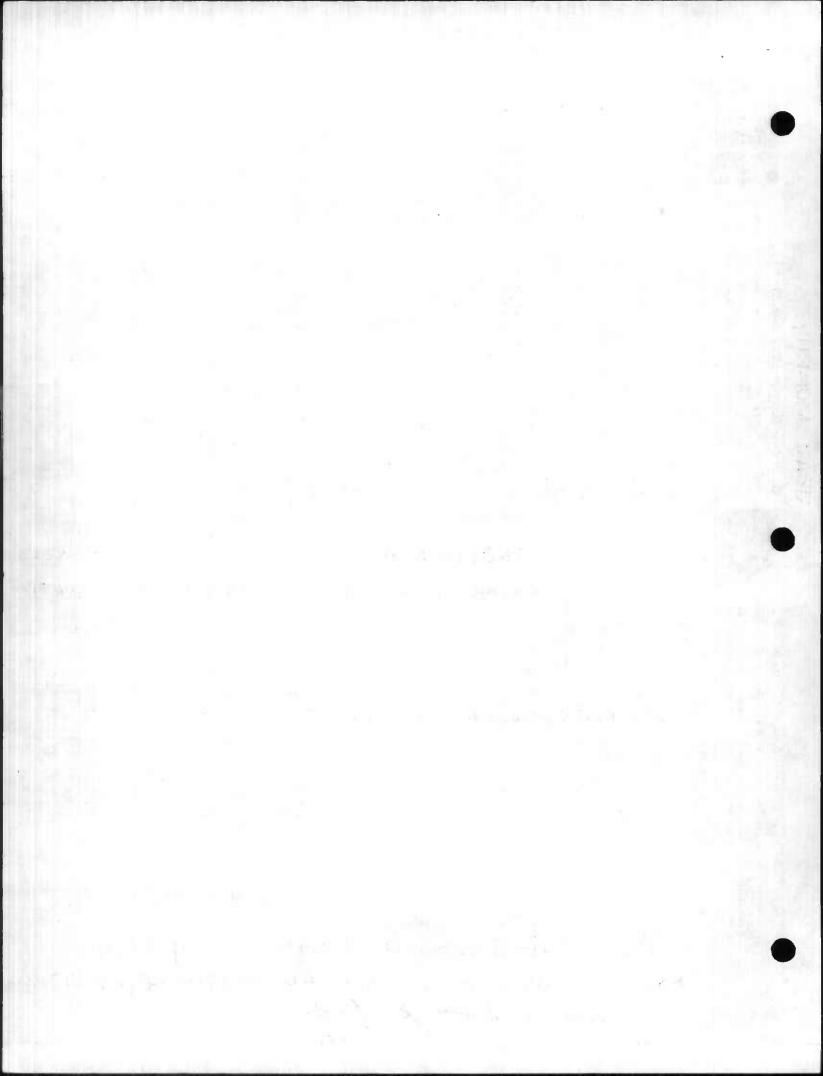


## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99

99 00646

				Certifica	ate of	Death		Reg. No.		
Discolation	1. Decedent's Name (First, Midd	de, Last)				Tale 1	2. Dete of D Month	eath Dev	Yeer	3. Time of Death
Physician /Medical	John Leo Virg	il Murphy, J	r.				Januar		1999	7:55 PM
Examiner	4e Facility Neme (If not institution	on, give street and number	r)			4b. City, Town, o	or Location of Dea	th 4c. County	of Death	
QL I	Manor Care -		0			Towson		Balti		
Funeral Director	5. Social Security Number 213–18–9620	6. Sex 1 ★ M 2 ☐ F	Nge (In yrs. last b	Yrs. If Und Month	der 1 Year S Days	If Under 24 H Hours Mi		6, 1914	Cour	place (State or Foreign http:) Land
2	Usual Residence of Decedent  10a. Stete 10b. Count	v	10c. City. To	wn or Location	100		-		1	10d. Inside City Limits
ver the Maryla or 28s-f sho be notified at Director	Maryland Balti		Baltin	nore						1 ☐ Yes 2 No
5 54 0	1006 W. Lake	Avenue			Zip Code 1210			United		•
020 un after death v st, or items 23 Examiner mast by Furneral	11. Meritel Stetus  1 Never Merried 2 Me  3 Widowed 4 Divorce	If Yes Give	i? ] No		cedent of F pecify Cub 2 No		(Specify Yes or Nerto Rican, etc.)	lo- 14. Rec Bia Specif	ck, White,	can Indien, etc.
Maryland 21215-0020 d 2 should be fited within 72 hours ethin and Merital Hygiene. The marked other than "netural", or treumetic event, the Medical Exami To Be Completed by F	15. Decede (Specify only high	nt's Education est grade completed)  Coilege (1-4or		a. Decedent's Us (Give kind of I life. DO NOT	suel Occup work done use retire	pation during most of w d)	vorking	16b. Kind of B	usiness/In	dustry
21 Page 1	and more years and the second	5+	(	Civil En	gine	er		City G	overr	nment
be filed d other event, II	17. Father's Neme (First, Middle	, Last)				18. Mother's N	ame (First, Middl	e, Maiden Sumer	ne)	
Vlar Manual Ma Manual Manual Manual Manual Manual Manual Manual Manual Manual M	John Leo Virg	il Murphy, S	Sr.	CITE TO		Edith	Hamilton 1 4 1	Meyer		
Aar and and	19a. Informant's Name/Raietion							ber, City or Town		
E 22 M P	Elizabeth R.	Murphy / Wif	e 1	L006 W.	Lake	e Avenue	Baltin	nore, Mai	cylan	d 21210
Baltimore, semit. Pages 1 m Peparhment of Hes mportant: if Hem my injury or othe sons.	20e. Method of Disposition  1 X Burial 2 Cremetion 4 Donation 5 Other (		cemet	of Disposition (A ery, cremetory of ney Vall	r other ple		Dete 1/18/99	20c. Location Timoni		own, State Maryland
Baltimor permit. Pages Department of Important: If its any injury or o	21. Signeture of Funerel Service	Licansee		22. Name Mitch	end Addre	ss of Facility Wiedefe	Ld Home,	Inc. e, Maryl	and S	01010
	23a. Part1. Entar the diseese, of shock, or heart feilure. Lis	or complications that cause	ed the deeth. Do						aru z	Approximete
Physician	SHOCK, OF HEART TERROTE. EIS	orly one couse on each	iirie.							Intarval Between Onset end Deeth
/Medicat	Immediate Cause (Finel disease or condition	PNF	UMON	VIA					1	4 WEEKS
Examiner	resulting In deeth)	a. 1110		consequence o	4).				1	1 - 00 100
je		CHRONI				PUL MI	NARY	D1867	SE	IN YEAR
Box 68760, seth certificate be executed attending physician and for use as the burial-transit clary/Medical Examiner	Sequentially list conditions.	6.0110100		consequence o		10010		. (50)		10 101.0
Ex Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								i	
68760, ifficate be exagging a physician a as the burial-ledical Ex	that initiated evants	C	Due to (or as e	consequence of	f):					
K 68	resulting in death) Last				•				1	
Box bath cert for use		d							-	
. 0	Pert II. Other significant conditi	ona contributing to deeth	but not rasulting	In the underlying	cause giv	ven in Pert I.	23b. Di	d tobacco use co	ontribute t	o the cause of death?
that the ded by detac	CEREBRO	V ASCUL	AR 1	ACCIP	EN	T	10	2□ No	3 □ Pro	bably 4 Unknown
Cords requires been sign should be							24a. We	s an autopsy formed?	ev	ara autopsy findings railable prior to
aw ra							-		of	ompletion of cause death?
I Rec The law ate has b page 2 s							10	Yes 200 No	11	□Yas 2□ No
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bysici hysici his ce il direc	examiner? 1 Yes 2 No	Hospital:	tient 2 ER/C	Outpatient 3 1	DOA Ott	ner: 4 M Nursing	Home 5 □ Re	sidence 6 □Otl	ner (Speci	fy)
Physical dispersal di	27. Menner of Deeth	28e. Dete of In (Month, D	jury 28b	. Time of	28c. Inju			how injury occu		
Vision of Vita Attending Physician: r death. ector: After this certific by the funeral director, liftcation: To Be (	1 Netural 5 Pendi 2 Accident invest	tigetion (Monin, D	ay rear)	Injury M		Yes 2□No				
Divis at or Attent to Director of in by th	3 Suicide 6 Could deten	mined 286. Placa of II	njury - At home, etc. (Specify)	farm, street, fact	ory, office			(Street and Num own, Stata)	ber or Run	al Routa Number,
Division of Vital Record To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should Medical Certification: To Be Completed	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physicien: To the bes I Examiner: On the basis and manner s	of axamination a	ge, deeth occurre and/or invastigation	ed at the time on, in my o	me, data end pla opinion, daath oc	ce, and due to th curred at tha time	e cause(s) end m n, data and place,	anner as s and due t	stated. o the cause(s)
M M	29b. Signeture end title of certific	er )		2	29c. Licens	se number		29d. Date signe	ed (Month,	Day, Year)
	/ Manu	1VI-an	mes 1	MP	D3	8950	)	1115	190	7
	30. Name and address of persor	who completed cause of	deeth (Item 23a	) (Type, Print)			0	1.	1	
1.0	MANUEZV	RA MOS,	MO U	800 V	OPK	LRO,	BAZT	MORE	M	021212
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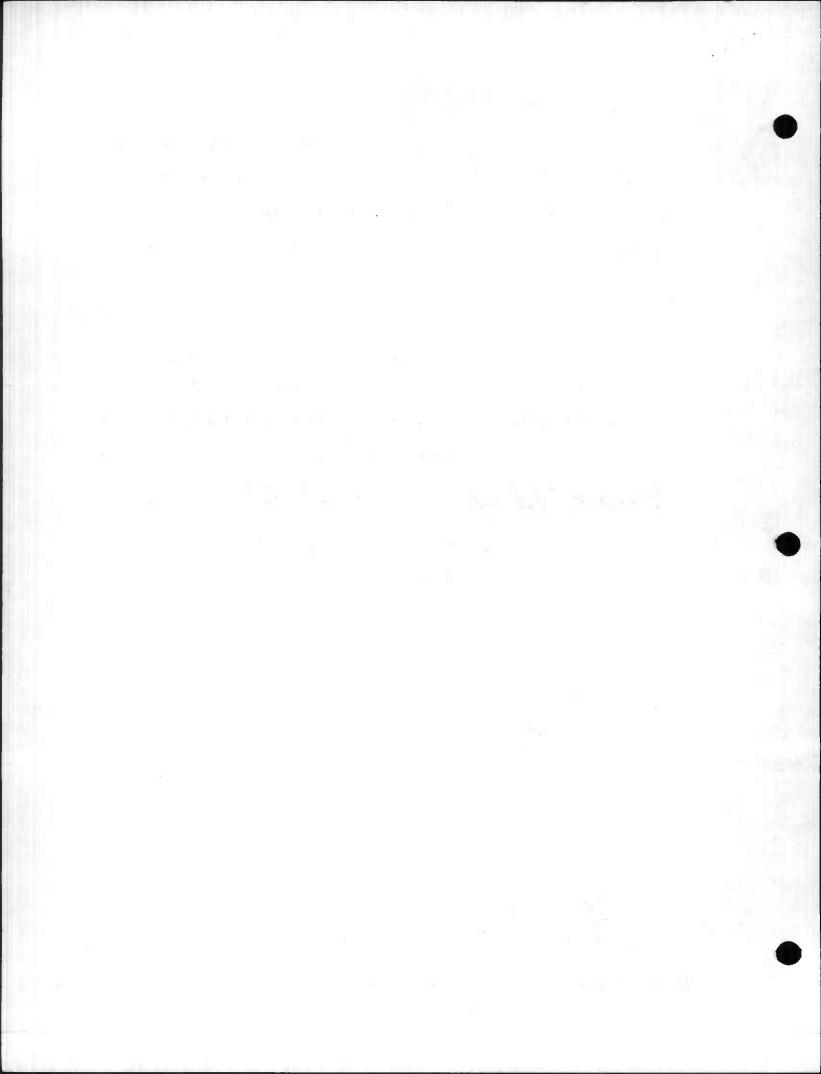


## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Deeth 3. Tima of Death **Physician** Month Year JOHN WALTER OSTROWSKI /Medical 11 1999 5:15 PM JAN. 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BaltimoreCounty Baltimore Stell Maris If Under 1 Year If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral**  Birthplaca (Stata or Foreign Country) Days Months Hours XX M 2□ F Yrs. Director 217-03-3481 May 23, 1908 Poland the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exercises must be notified at Baltimore County Baltimore Maryland Director 1 Yas XX No 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? USA 21206 524 Elmwood Rd. filed within 72 hours after death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 11. Maritai Stefus Was Decedant of Hispanic Origin? (Specify Yes or No. If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarlcan Indian, Bleck, Whita, atc. 1 Navar Merried 2 Marriad 1 ☐ Yas 2 No If Yas, Give Yaar or Datas: 21215-0020 1 ☐ Yas 2 No Specify: Specify: White Completed by XXWidowad 4 □ Divorced 15. Dacadant's Education (Spacify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry al Hygiene. Elamantary/Secondary (0-12) Collage (1-4or 5+) permit. Peges 1 and 2 should be filed w Depertment of Health end Mental Hygier Important: if item 27 is marked other th any Injury or other traumatic event, the once. UNKNOWN 17. Fathar's Nama (First, Middla, Last) Md. State Penn. Guard Baltimore, Maryland 18. Mother's Nama (First, Middla, Maidan Sumama) Be John Ostrowski Helen Unknown 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 3128 Laurel View Dr. Abingdon, Md. 21009 Mrs. Valerie Huemmer 20b. Placa of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Gardens of Faith CEm. 1-14-1999 XIX Buriai 2 Cramation 3 Ramoval from State Baltimore, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama end Addrass of Facility
Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximata Intarvai Batween Onsat and Death **Physician** /Medical Immediata Causa (Finai disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of): V/2410 35 2 162/3 The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaasa or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by lung discuss 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 No certificate or Attending Physician: Be 25. Was casa rafarrad to medical 28. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 this funeral 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred After 1 Natural 5 Panding death. 1 Tas 2 No Invastigation after death 2 Accident 6 Could not be dataminad 28a. Piace of Injury - At homa, ferm, straat, factory, offica building, atc. (Spacify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 Suicide in by 4 Homicide • Funerel The Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

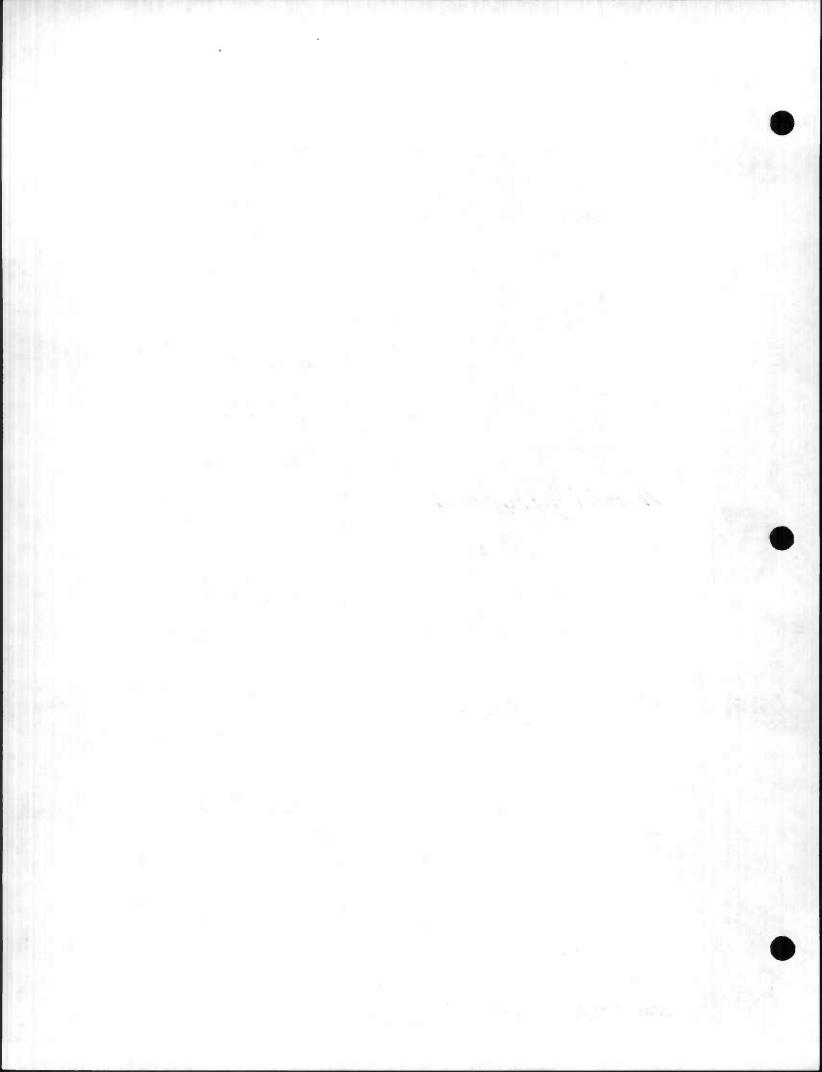
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical (Check only one) To the within 2 29b. Signatura and 29d. Data signed (Month, Day, Year) 12.99. per 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print) TIMONIUM, MD Z1093 2300 DULANEX Eddie Nakhuda MD VALLEY ROAD 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State 5 Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 0648

			C	ertificate o	f Death	Re	g. No.	
	1. Decedent's Neme (First, Middle, La	st)				2. Dete of Death		3. Time of Death
Physician /Medica	Frank Panzarasa				4b. City, Town, or I	Month  SANUARY  cocation of Death	Day Year 11 1789 4c. County of Death	130 AM
Examine	Fallston General				Fallston		Harford	
Funeral	5. Social Security Number 6. 5	Sex 7. Age (In	yrs. last birtho	(ay) If Under 1 Yes	ar If Under 24 Hrs.	8. Dete of Birth (Month, Day,		pleca (State or Foreign
Director	214 30 0777	¹\\\ 2□F \ 79	Yrs	s. Months Day			. 1919 Ita	
Pu s	Usual Residence of Decedent  10a. Stete 10b. County	10	c. City, Town o	r 1 ocation			·	10d. Inside City Limits
Aarylar I ahow			aldwin					1 ☐ Yes x2√2 No
the Maryle 28s-1 shor	10e. Street and Number	i c	arawrii	10f. Zip Code		10	g. Citizen of What Cou	ntry?
020 urs after death with the Maryland al, or items 23s or 28s-f show sarding man be notified a	2710 Raynham Cou	rt		21013	3		U.S.A.	
Herra Rema	11. Meritel Stetus	12. Wes Decedent Ever Armed Forces?	r in U,S.	<ol> <li>Was Decedent of If Yes, specify Co</li> </ol>	f Hispanic Origin? (S uban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Bleck, White,	
5-0020 72 hours after natural; or its	1 Never Memied 2 Merried 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Yeer or Detes:		1□ Yes 2□ N	lo Specify:		Specify:	
21215-0020 d within 72 hours aff piene. rr than "natural", or tre Midical Enerr	15. Decedent's E		16a De	ecedent's Usuel Occ	anation	1	6b. Kind of Business/m	dustry
T C	(Specify only highest gra	ade completed)	(G	live kind of work dor ie. DO NOT use reti	ne during most of wor ired)	king	00. 14.14 01 00011000111	doday
d within giene.	Elementery/Secondary (0-12)	College (1-4or 5+)	Bake	er		E	Bakery	
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1 end 2 should be flied within Health and Mental Hygiene. fem 27 is marked other than other traumatic event, tre-	Carlo Panzarasa				Maria R	abai		
and le ma	19a. Informant's Neme/Reletionship (	Type, Print)					City or Town, State, Zij	
1 end 1 Health em 27	Maria A. Miller				n Court Ba		ryland 210	
6 B	20e. Method of Disposition 1 XBurial 2 Cremetion 3		cometery,	sposition (Neme of cremetory or other p	olece)	Dete 2	0c. Location - City or To	own, Stete
tmen tant: jury	4 Donetion 5 Other (Specif	Д.	loly Red	leemer Ce		1/14/99 E	Baltimore,	Maryland
permit. Pages 1 er Department of Hea Important: If Nem 2 any Injury or other phose.	21. Signeture of Funerel Service Licer	nsee	0	22. Name end Add	dress of Fecility Dip	pel Funer	al Home In	c.
20260	marilen	- DIDDER	12	7110 Bela:	ir Road Ba	ltimore.	Maryland 2	
	23a. Part1. Enter the diseese, of comshock, or heert feilure. List only	plications that caused the	deeth. Do not	enter the mode of d	lying, such es cardiac	or respiratory erre	st,	Approximate Interval Between
Physician /Medical	L	1) 1	- 0	//	/			Onset and Death
Examiner	Immediate Cause (Finel disease or condition resulting In death)	en trac	eret?	il hes	na fema	2		3 DAYS
		Due	to (or as a cor	sequence of):				
uted ansit	Comments the tree of the comments	b.	to (or as a con	ecomoco off:			-	
in an	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury	500	to (or as a cor	sequence or).				
ng physician and set the burial-transit	Ceuse (Disease or Injury that initiated events resulting in death) Last	c. Due	to (or as e con	sequence of):				
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attendii	Death Other shelds and shelds					00b Dida-6		
Attending Physician: The law requires that the death certificate be executed death.  stor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transitions. To Be Completed by Dhysician Manales in Exemple	Pert II. Other algoriticant conditions of	contributing to death but no	or resurring in th	e underlying cause	given in Pert I.	23b. Did tob	secco use contributa t	o the cause of death?
cian: The law requires that the death ce afficials has been signed by the attendi scior, page 2 should be detached for use Bached for use afficial and the back to be afficially the statement of	" washe	ye	long			1 1 72	■ 2□NO 3□PNO	Jacky 4 Unknown
en sig		/				24a. Wes an		ere autopsy findings reilable prior to
2 shoul						ponom	CC	ompletion of cause death?
page 2						1 ☐ Yes	5 2 DN6 1	☐ Yes 2 ☐ No
rector, par	25. Was case referred to medical				26. Placa of Dea	ith (Check only one	)	
this certain direct		Hospitel: 1 Impatient	2 ER/Outpe	tient 3LI DOA		ome 5 Resider	nce 6 Other (Speci	fy)
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death. for: A the fu	2 Accident investigation	n		M 1	Yes 2 No			7
irect n by	3 Suicide 6 Could not be determined	28e. Pleca of Injury - building, etc. (S	At home, fem Specify)	, street, factory, offic	08	28f, Location (Str. City or Town,	eet and Number or Rur Stete)	al Route Number,
Hospital or A 24 hours after Funeral Director (1997) tely filled in by the	On Continue of						70.	
within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	29e. Certifier 1 Certifying Ph (Check only 2 Medicat Exer	yafcian: To the best of my niner: On the basis of exa	y knowledge, d minetion and/o	eeth occurred at the r investigation, in m	time, date end place y opinion, deeth occu	, and due to the car rred at the time, da	use(s) and manner es a te and place, and due t	stated. to the cause(s)
within 2 To the		and manner steted.	0	29c. Lice	ense number	29	d. Date signed (Month,	Day, Year)
¥ <b>≥</b> 8	1/2 -4/	27.	V4	- 10	1417	/	1/11/0	c
	1 anaprole	down	ena	1000/44	11121		1/11/7	7
\$	30. Name and address of person who		(item 23a) (Ty	MA () 181	U 181 A1	POAD I	ALLSTON 1	UAL YI AND
State	31. Date filed (Month, Dey, Year)	32. Registrer's	Signeture	101	7 1/10/1/1	Kon, F	Mar 11 on	2
Panistra	JAN 1 5 1999	heres	4 1					21047



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Dev Month Year Pembroke 1999 11:55 PM Helen 12 ernice 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Center-Genesis Eldercare

7. Age (In yrs. lest birthdey)

H Under 1 Year

Months Deys Baltimore Green Long G

5. Social Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 6. Sex 1 M 2 F 5-18-5997 9 -192 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e. Stete 10b. County NA 1 ☐ Yes 2 ☐ No Baltimore Ma 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.H Hvenge 21212 5 Melrose 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give / Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Meritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□ Yes 2X No Black Specify. 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry rivate Hom es Elementery/Secondery (0-12) College (1-4or 5+) 12th grade NA omestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) New y Spriggs

190. Johnson 1's Name/Relationship (Type, Print)

Pembroke - Son Mary Williams 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Belair 21015 Whitney Cane Md 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removel from Stete Randallstown Memorial tark 1-16-99 4 Donetion 5 Other (Specify) Name end Address of Facility 21. Signeture of Funeral Service Licansee West Bake Md 23e. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 21215 Approximete Interval Between Onset and Deeth Immediate Ceuse (Final diseese or condition resulting in death) hemorrhagie Conjournt lweek Atknosclenoti Cerebrovajula Vea 15 Due to (or es a consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evallable prior to 24e. Wes en eutopsy performed? completion of cause of deeth?

**Physician** /Medical **Examiner** 

ettending physician and for use as the burial-transit

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certificate Physician:

Director: After this d in by the funeral di

or Attending

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within 24 hours of To the Funeral Di completely filled in the Hospital

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

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Completed

Be

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Certification:

edical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

by

Completed

7 is marked other than "natural", or items 23s or 28s-f show traumatic svent, the Medical Examinat must be notified at

with the Maryland

death

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or I any Injury or other traumatic svent, the Magical Expensions.

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest

Amail Rhullakon Ascrout inopeable aronary steroses Vasular perpeal 25. Wes case referred to medical exeminer? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Dursing Home 5 Residence 6 Other (Specify)

1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one)

1 Yes 2 No 27. Menner of Deeth 5 Pending investigation 2 Accident

6 Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of Injury

28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Sulcide

4 Homiclde

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner as steled.

2 Madical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and pieca, end due to the ceuse(s) and menner steled. 29c. License number

29b. Signature and title of certifie

ArkadiNE

Baltwee

29d. Dete signed (Month, Dey, Year) 99 13

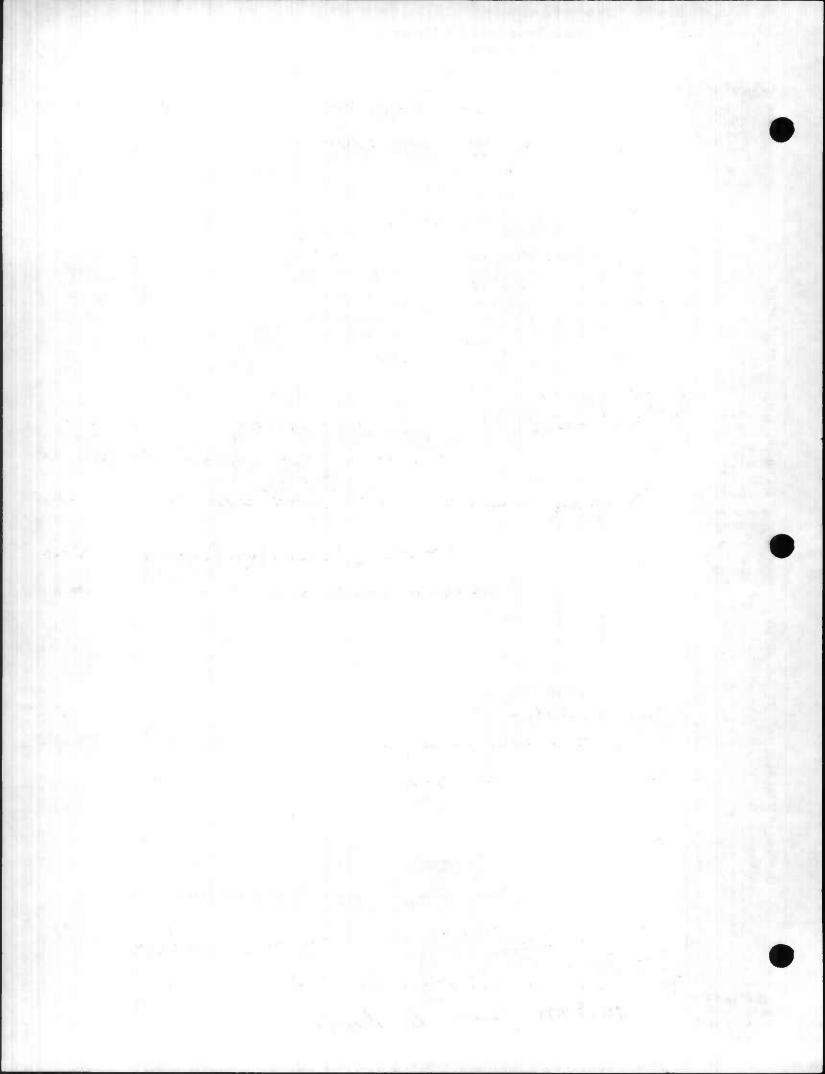
30. Neme end eddress of person who completed cause of deeth (item 23e) (Type, Print)

PAUL Schwartz MD. 115 E. Nelcare

31. Date filed (Month, Day, Year) 32, Registrer's Signeture

1999

State Registra



	P		Fleas	State of M		nd / D	epartm	ent of		d Mental Hy	, , ,	ble.	0650
	Physic /Med		1. Decedant's Name (First, Middla, L LER6Y PE	asi) EDDY	T.		1			2. Data of De Month	eth Day	Yaar 1999	3. Tima of Death
	Exami		4e. Facility Name (If not Institution, g							or Location of Deat	4c. Count	y of Death	
L	Francis	P	Blakehurst Life 5. Social Sacurity Number 6.		nity ga (In yrs.	last hirth	devi If Ur	nder 1 Year	Tows			ltimo:	
	Funeral Director	_	218-32-3057 Usual Rasidence of Dacedant	1ÅM 2□F	92	Υ	Mont	hs Days		in. (Month, De	14,190	o Ge	laca (State or Foraign try) Orgia
	sa-f show	Director	Maryland Baltin	ore		y, Town Tows	or Location On					1	0d. Inside City Limits 1 ☐ Yas 2 No
	ath with the 123s or 2 sunt be no	ral Dire	10e. Street and Number 1055 W. Joppa Rd				10f.	Zlp Code 2120	4		10g. Citizan of United		*
020	urs after de al', or item	by Funeral	11. Marital Status  1 □ Navar Merried 2 □ Marrled  3 ◯ Widowad 4 □ Divorced	12. Was Decadant Armed Forcas? 1 X Yes 2 ☐ If Yes, Giva Yaar or Detes:				ecedant of specify Cut		(Specify Yas or No arto Ricen, etc.)	14. Ra Bla Specia	ce - Amaric ick, Whita, fy: Whi	atc.
21215-0020	be filed within 72 hours after death with the Maryland itel Hyglene. Id other than "natural", or items 23s or 28s-f show event, the Medical Exertine must be inclined at	Completed	15. Decadant's I (Specify only highast g Elamantary/Secondary (0-12)	Education reda completed)  College (1-4or	5+)	(	Decedant's L Giva kind of ifa. DO NO	work done Tusa retire	during most of i	vorking	16b. Kind of B	usiness/Ind	
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Ma	d 2 and 7 is		19e. Informant's Name/Ralationship Lori P. Spencer/						iand Number or ir Rd.	Rural Route Number Baldwin		, Stata, Zip 1013	Coda)
a,	ges 1 and it of Health If Item 27 or other tr		20a. Method of Disposition		20b. P	laca of E	Disposition (	Name of		Datuwill	20c. Location		wn. Stete
altimore,	Peges net of I		1 Burial 2 Crametion 3 4 Donation 5 Other (Spec	Removal from Stata			oramatory o		,	1/13/99			
Balti	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funaral Service Lice		Z				ass of FacilityM-	tchell-W 000 York altimore,	iedefe1		
	Physician		23a Fant Enfer the disease, or cor hock or haart failure. List only	nplications that caused y ona causa on each li	tha deati	h. Do no	t antar the n	noda of dy	ing, such as cerd	iac or raspiratory e	rest,		Approximata Interval Batween Onset and Death
,	/Medicai Examiner		tmmediate Cause (Final disaasa or condition rasulting in daath)	a. RESP	nn	TON	YF	Arc	une				1 wic
_	D ==	ner	AND THE STATE OF T	b. PNEU				or):				1	
on,	be executed Iclan and buriel-transit	al Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b			nsequence	of):					
20 x 00 /	certificate iding physise es the	Physician/Medica	that initiated avants resulting in daath) Last	d	Dua to (or	as e co	nsaquance o	of):					9
	0 0	sicial	Part II. Other eignificant conditions	contributing to death b	ut not resu	ultina In ti	ha undarivin	n ceusa ni	ven in Part I	23h Did i	obecco use co	ntribute to	the causa of death?
S, T.O	requires that the death seen signed by the ette hould be deteched for	by Phys											abty 4 ☐ Unknowr
ecords,	need	Completed	CVA (CEN	BNOVAS	CUU	m	Dis	corsi	-)	24e. Wes perfo	an autopsy med?	ava	ra autopsy findings diabla prior to applation of ceusa death?
Tall I	sician: The lew certificate has b lirector, page 2 s									101	es 2 No	1 🗆	Yes 2□No
5	siciar certif irecto	o Be	25. Was cesa rafarrad to medicel examinar?  1 ☐ Yas 2 ☐ No	Hospital:				Ot		aath (Check only o			
5	Attending Physician: or death. octor: After this certific: by the funerel director,		27. Menner of Death	1 ☐ Inpatia 28a. Data of Inju	ry	28b. Tin	na of	28c. Inju Wo	4 E Nursing	Homa 5 Resid			)
2	auth. or: Aft	atio	1 ☐ Naturel 5 ☐ Panding 2 ☐ Accidant invastigation		Year)	Inju	Iry M		Yes 2 No				
	P P P	Certification:	3 Sulcida 6 Could not to datermined	28a. Place of Injubulding, atd	ury - At ho	ma, farm	, straat, fact	ory, office		28f. Location (S City or Tou	Straat and Num I m, Stata)	per or Rural	Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Cartifiar (Check only one)	nysician: To the best of miner: On the basis of end manner sta	axamınat	vledge, d ion and/o	aath occurre or Investigati	ed at tha ti	ma, date end pla opinion, daath oc	ca, and due to tha c curred et the tima,	cause(s) end me date and place,	ennar es sta and due to	ated. the ceuse(s)
	To th To th comp	Me	29b. Signature end titla of certifier	- /	)		- 2	29c. Licans	sa number		29d. Data signe	d (Month, D	Dey, Year)

State Registrar

Vincent DiPietro, M.D.

31. Data filed (Month, Dey, Year)

JAN 15 1999

D. 7801 York Rd., #102 Towson, MD 21286
32. Registrar's Signatura

D28812

30. Nema and address of person who completed ceusa of death (Item 23e) (Type-Print)

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Division of Vital Records, P.O. Box 68760

31. Date filed (Month, Day, Year) State JAN 1 5 1999 Registrar

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32. Registrer's Signeture

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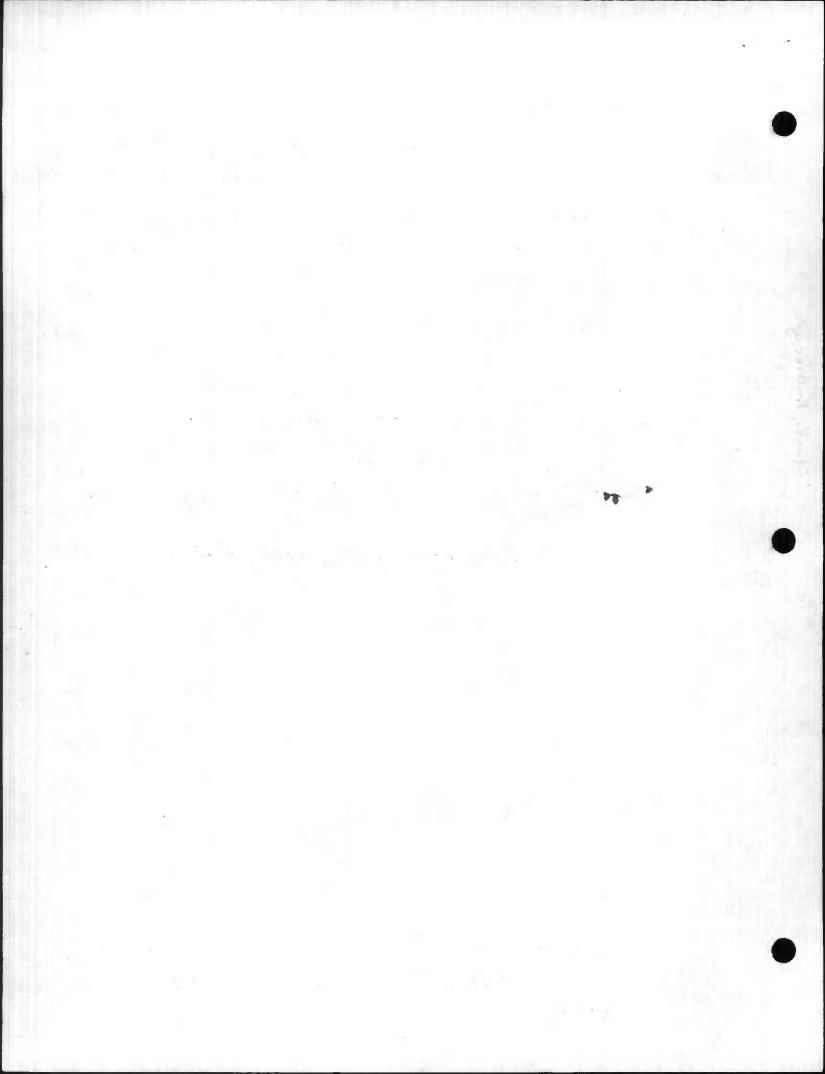
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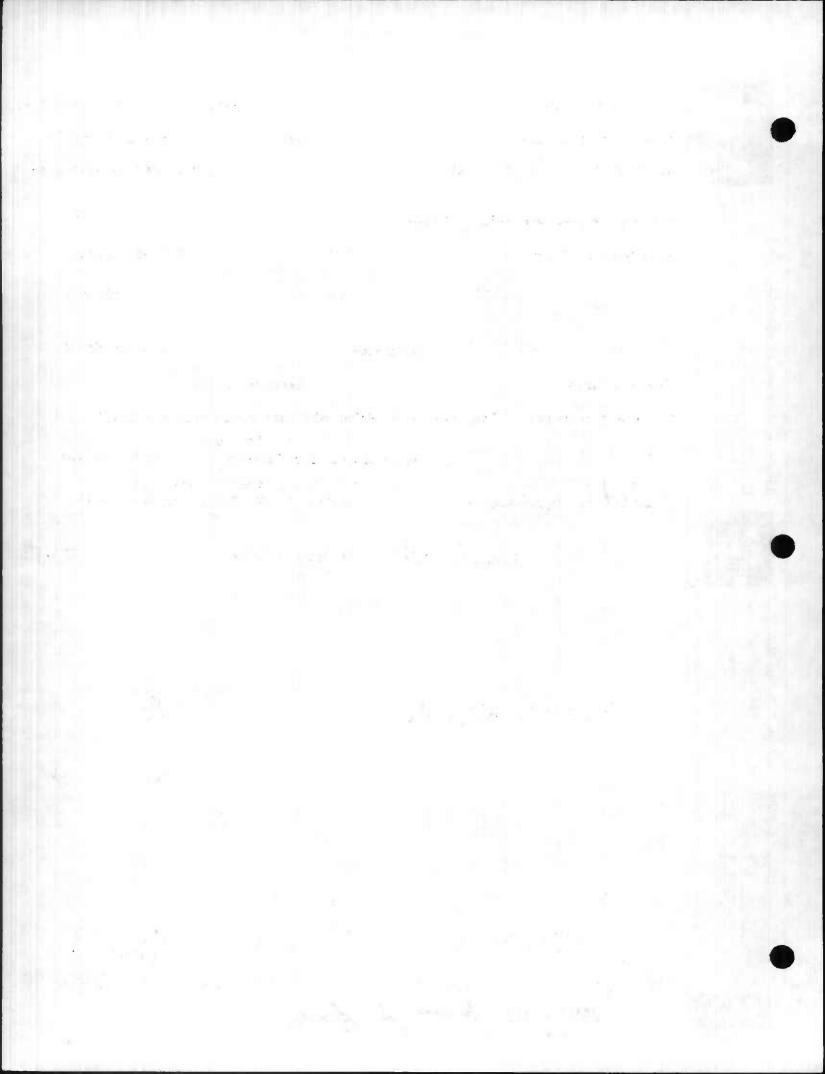
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Katheryn Victoria Park 1999 01:55 AM **JANUARY** /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yea If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 75 Director 244-32-4007 Aug. 23 1923 North Carolina Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits 1 Yas 2 XNo McLean VA Fairfax Director 28m-f 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 8 22101 1004 Heather Hill Court USA Berns 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American indien, Bleck, White, etc. 1 Never Married 2 Merried b 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 3 Widowed 4 Divorced Completed Paule, Katheryn 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Own Home Homemaker 12 n/a 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First Middle Last) Be Agnes Naomi Cress David Homer Corl 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Neme/Reletionship (Type, Print) Separtment of Health an important: If Item 27 is 14202 Dovecreek Way, Unit 102, Sparks, MD 21152 Sherry P. Kovalchik/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 1/13/99 Date 20c. Location - City or Town, Stete Buriai 2 □ Cremetion 3 □ Removel from Stete Dulaney Valley Memorial Gardens Timonium, MD 21093 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Er 22. Name and Address of Fecility Lemmon Funeral Home Michael Flagle 10 W. Padonia Rd., Timonium, MD 21093 23a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Respiratory ForTore /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditiona, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initialed events to (or as a consequence of) KMENTA Box 68760 the death certificate be Physician/Medical thet initieted events resulting in death) Lest Due to (or es a consequence of): Pert il. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. the signed by t 1 Yes 2 No 3 Probably 4 Unknown P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d, Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending investigation n 24 hours after death. he Funeral Director: Afte pletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier edical (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BILTIMORD, MD of death (Item 23a) (Type, Print) 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State JAN 15 Registrar



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	Certificate of Death		Reg. No.	
Dhuaisia	Decedent's Name (First, Middle, Last)	2. Date of De Month	Day	3. Time of Death
Physicia /Medica	Janet II. Kitch	Jan.	9 19	99 4:00 A.1
Examine	4a Facility Name (If not institution, give street end number) 4b. City, Town, o	Location of Deat		
	4002 Wakefield Lane Bowie  5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) If Under 1 Year If Under 24 Hi	S 9 Date of Bir		e George's
Funeral Director	292 38 2087 1 M 2 F 55 Yrs. Months Days Hours Min	/Month. Da	1, 1943	9. Birthplace (State or Fore Country) Pennsylvania
and land	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limi
Mary	Maryland Prince George's Bowie			XX Yes 2□
th with the Marylar 23a or 28a-f ehow	Maryland Prince George's Bowie  10e. Street end Number 4002 Wakefield Lane 11. Meritel Stetus 1 □ Never Married 2 □ Married 1 □ Yes ※⊠ No  10f. Zip Code 20715 11. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes ※⊠ No		10g. Citizen of W	hat Country?
th wil	4002 Wakefield Lane 20715		United	States
items items	11. Meritel Stetus  12. Wes Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispenic Orlgin? If Yes, specify Cuben, Mexican, Pus	Specify Yes or No rto Rican, etc.)	- 14. Rece Biaci	- American Indian, c, White, etc.
5-0020 72 hours effer death with the Maryland natural; or frems 23s or 28s-f show are it Examples to notified at	1  Never Married 2 Married 1  Yes X⊠ No If Yes, Give 1 Yes 2 X™ Specify:  3  Widowed 4 → Toronto Year or Dates:		Specify:	White
21215-0020 d within 72 hours ef gjene. The matural', or The Medical Exert	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Bu	siness/Industry
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Datumore, Maryland 41413-0040 permit. Pages 1 end 2 should be filed within 72 hours eft Department of Health and Mentel thygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, tra Madrell Event	19a. Informant's Name/Relationship (Type, Print)  Tracy Shallenberger Daughter 4002 Wakefield Lane	Ru <i>ral Rou</i> te Numb	er, City or Town,	
Heal Heal	20a. Method of Disposition  20b. Place of Disposition (Name of cametery, crametory or other piece) Jan.	3 Date 99	20c. Location -	City or Town, State
Pages nent of 1	to Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify)  Susquehanna Memorial Gar		York P	ennsylvania
Balti permit. I Departm Importa any inju	21. Signature   Funeral Service Licensee   22. Name and Address of Facility   Robert E. Evans Fr		ma Ina	
Deparimpor	16000 Annapolis Ro			
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/Medical Examiner	Immediate Causa (Final disease or condition resulting in death)  a. 100 TDOQUUS YUUDUO	Ma		TYPE
0.00	Due to (or as a consequence of):			
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v requires that the death cert been signed by the attendin should be deteched for use	Pert II. Other algorificent conditions contributing to deeth buf not resulting in the underlying cause given in Part I.  DIAGES MCILTUS	22b Did	tobassa usa sag	tribute to the cause of dea
of the de by the set checker	Pert II. Other algnificent conditions contributing to deeth buf not resulting in the underlying cause given in Part I.		Yaa 20 No	3 Probably 4 Unkne
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equire sen signould to		24a. Was perf	an autopsy ormed?	24b. Ware autopsy finding available prior to
law r				completion of cause of death?
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VICAL HE lav	25. Was case referred to medical examiner? Hospital: Other:	eath (Check only		
DIVISION Of VITAI RECORDS, or Attending Physician: The law requires to effer death.  Director: After this certificate has been signed in by the funeral director, page 2 should be on the funeral director.	1   Yes 2   No	1.	idence 6 Other how injury occurr	
nding F Ith. :: After e funer	Natural 5 Pending (Month, Dey Year) Injury Work?  Accident investigation M 1 Yes 2 No			
VISIO Attendii er death. ector: A by the ft	3 Sulcide 6 Could not be determined 4 Homicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)		Street end Numb	er or Rural Route Number,
tal or is effect in bell in bell in the circumstance of the circum	building, etc. (opeciny)			
DIVISION OT VITAI HER To the Hospital or Attending Physician: The law within 24 hours effer death.  To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2	25. Was case referred to medical examiner?  1	ce, and due to the curred et the time,	causa(s) and ma date and place, a	nnar as stated. and dua to tha causa(s)
thin 2 the omple	and menner stated.  29g. License number,		29d. Daté signed	(Month, Day Year)
F 3 F 8	Voter Charge (MD) D16260	,	1/15	>199
1	30 Naminand address of person who completed cause of death (itam 23a) (Type, Print)	,	1110	~ · · · · · · · · · · · · · · · · · · ·
	HOPPIKGIRE MID 100 POSTQUIER	ND &	NODO /	3 11/2 31/4
State	31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture		1	
Registra	JAN 1 5 1999 Dereva B. Sparks			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Neme (First, Middla, Last) 2. Deta of Death 3. Time of Death Dev Month Year **Physician** Martha Mary Slaga January 15 1999 6:45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 6918 Sollers Point Rd Dundalk Baltimore If Undar 1 Yaar If Undar 24 Hrs. Hours Min. 8. Deta of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys Months 1 M 2 KF 212-09-6277 86 Yrs May 10, 1912 MD Director Usual Residence of Decedent deeth with the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at 1 ☐ Yas 2 No Director MD Baltimore Dundalk 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6918 Sollers Point Rd 21222 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces?

1 Yes 2 No !! Yas, Give Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, atc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 Widowed 4 □ Divorced Year or Dates: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed will Department of Health and Mentel Hygien. Important: if item 27 is marked other that any injury or other traumatic event, the once. Import/Export Receptionist 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Stanislaw Majewski Franziska Rubezirk 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 6918 Sollers Point Rd Baltimore, MD 21222 Maryann Sadowski /sister 20b. Plece of Disposition (Neme of Jan 18 20e. Method of Disposition 20c. Location - City or Town, Stete cemetery, cremetory or other piece) 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Holy Cross Cemetery Baltimore, MD 22. Nama and Address of Facility
Connelly Funeral Home of Dundalk 21. Signature of Funaral Sarvice Licansae 7110 Sollers Point Rd 23a. Pent1. Enter the disaeses or complications that caused tha daal. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heer failure. Ust only one ceuse on aech lina. Approximete Interval Between Onset and Deeth Physician vioschette Carchovascular clies /Medicai Immediete Ceusa (Finel disease or condition resulting in deeth) Examiner Examiner requires that the death certificate be axecuted physician and s the burial-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events rasulting in death) Lest Due to (or es e consequence of): Physician/Medicai Due to (or es e consequence of): attending p Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the cause of death? detech 1 Yes 2 No 3 Probably 4 Unknown Diaketo mollitus Division of Vital Records. à Sign 24b. Were autopsy findings evallable prior to Completed 24e. Wes en eutopsy completion of cause of death? pege 2 s 1 Yes 2 No 1 Yes 2 No certificate Attending Physician: director, Be 25. Wes cese referred to medical exeminar? 26. Plece of Death (Check only ona) Other: 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending efter death. 1 ☐ Yes 2 ☐ No Investigation 6 Couid not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 6 filled in 24 hours Hospital 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and menner stated. Medical 29e. Certifier To the Hosp within 24 ho To the Fune completely f (Check only one) 29c. License number 29d. Data signed (Month, Dev. Year) 29b. Signature and little of certifier fa MO 0-18151 R 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Chi-Shiang Chen, M.D. 98 N. Broadway

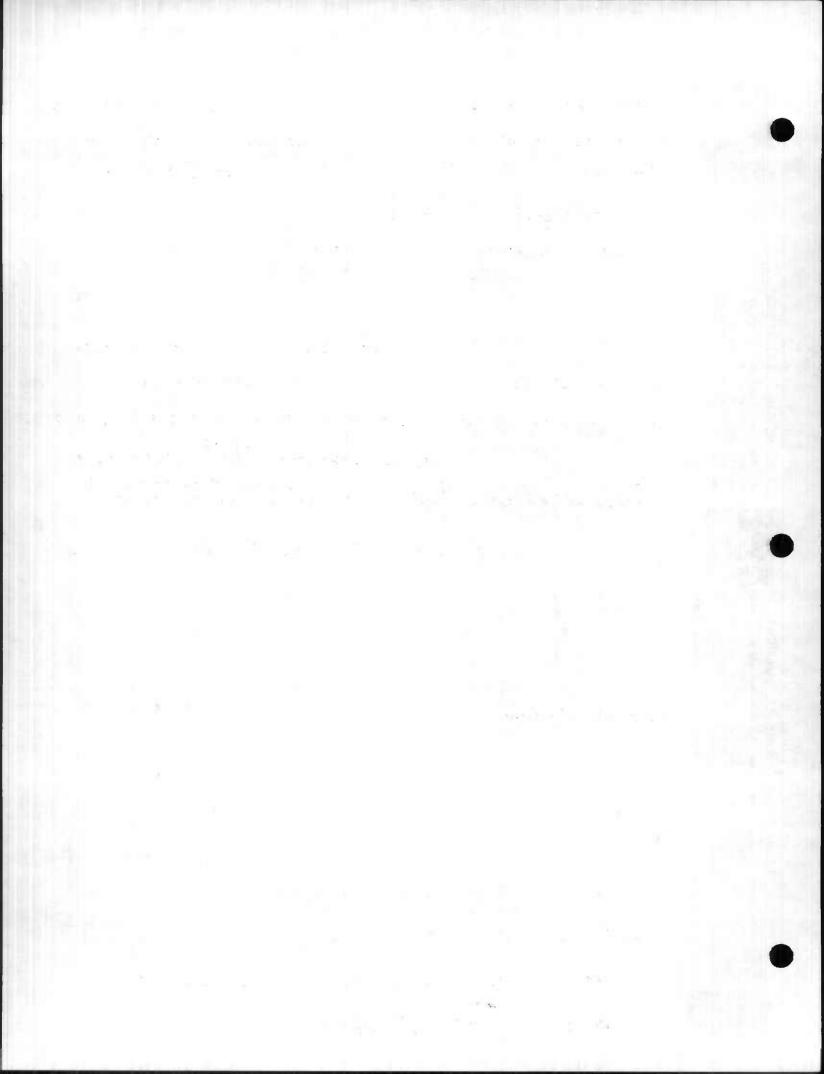
Baltimore, MD 21231

Registrar **DHMH 16 Rev 6/95** 

State

31. Dete filed (Month, Day, Year)

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Daath 3. Time of Death 12, 1999 Margaret E. Shannon Jan. 0145 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Spa Creek Center Annapolis Anne Arundel If Under 24 Hrs. 5. Social Sacurity Number tt Under 1 Year 8. Date of Birth (Month, Day, Year) Jan. 14, 1905 7. Age (fn yrs. last birthday) 9. Birthpiaca (Stata or Foreign Days 1 M 2 F 93 Yrs. 216-40-0144 Maryland Usual Rasidence of Decaden 10a, Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits Ohio N/A **Poland** 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 36 Poland Manor 44514 U.S.A. 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Orlgin? (Specify Yes or No-ff Yas, specify Cuben, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, White, etc. 1 Yas 2 No If Yas, Giva Yaar or Detas: 1 Navar Married 2 Married 1 Yas 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grada completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) 8 Homemaker Own Home 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maldan Surnama) John Dasch Mary Jurs 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Route Number, City or Town, State, Zip Coda) Thomas Shannon / Son 36 Poland Manor, Poland, Ohio 44514 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a, Mathod of Disposition 20c. Location - City or Town, Stata 1-15-99 Buriai 2 Crametion 3 Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore National Cemetery Baltimore, Md. 21. Signatura of Funeral Sarvica Licard 22. Nama and Addrass of Facility Moran-Ashton-Dabrowski Funeral Home, Inc. 3000 E. Baltimore St., Balto., Md. 21224 23a. Part1. Enter the disease, or complete the fluored by dead point enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart feiture. List only one cause of each line. Approximata Interval Batw Onsat and Death Immediata Causa (Final ellmony disaasa or condition rasulting in death) WKB Due to (or as a consequence of): Sequantially list conditions, if any, laading to immediata causa. Enter Undarlying Causa (Disaasa or injury Due to (or as a consequence of): thet initiated avants rasulting in death) Last Due to (or es a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributs to the cause of death? 1 ☐ Yes 2 No 3 □ Probably 4 □ Unknown 24b. Wara autopsy findings availebla prior to complation of causa of death? 24a. Was an autopsy performed? 1 Yas 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medical axaminar? 26. Pleca of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Deta of Injury (Month, Day Year) 27. Mennar of Death 28b. Tima of fnjury 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Natural 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be datarminad 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 3 Suicide 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 Homicida 29a, Certifia (Sartifying Physician: To the bast of my knowladge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and manner steted. (Check only one)

Examiner Box 68760. P.O. Records, Division of Vital

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72 hours after

Baltimore, Maryland 21215-0020

certificata be Attanding death. 124 hours efter death • Funeral Director: Joietaly filled in by the f ò To the Hosp within 24 ho To the Fune completaly fi

> State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) JAN 15

29b. Signature and title of certifier

Sprouse 2 32. Registrar's Signatura 1999

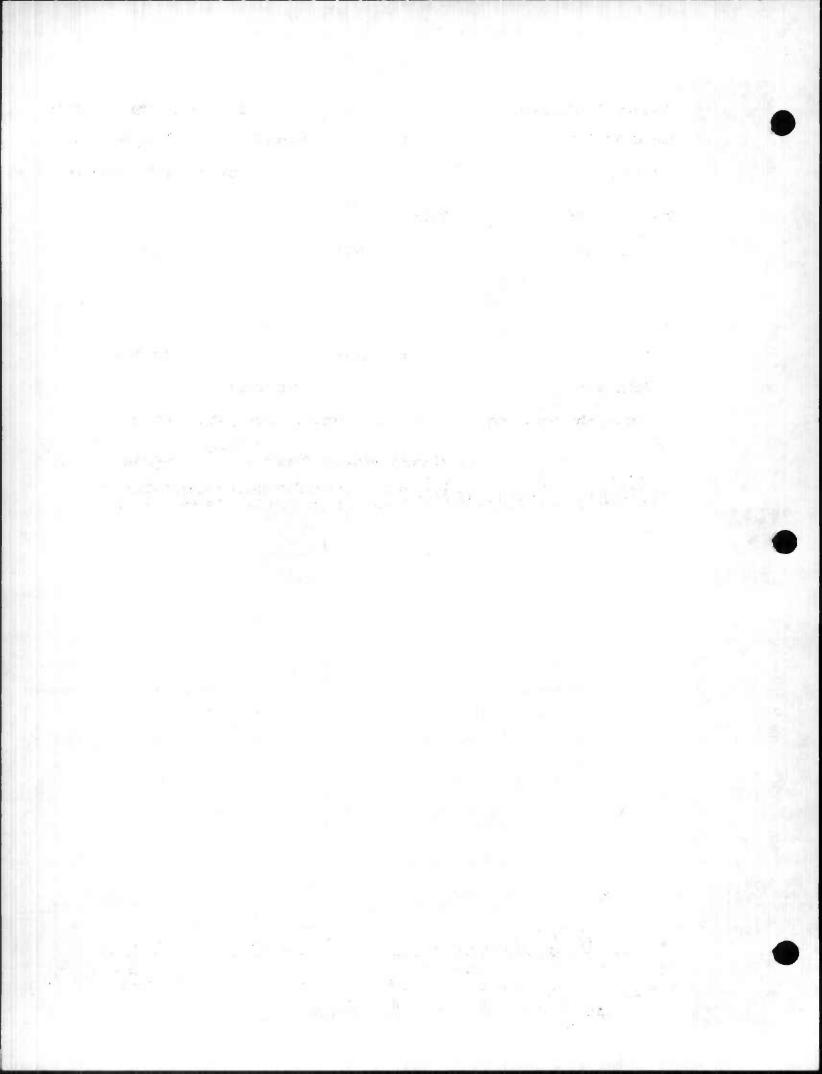
30. Name and address of person who completed causa of death (Itam 23a) (Type, Print)

29c. Licensa number

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29d. Data signed (Month, Day, Year)

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Examiner **Funeral** 

Director

with the Maryland 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner man be notified at permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a and highery or other traumatic event, the Wedes Examine man and DRGs.

Baltimore, Maryland 21215-0020 **Physician** /Medical Examiner The law requires that the death certificate be axecuted and -trans ettending physician a for use es the buriel-Division of Vital Records, P.O. Box 68760, the signed by the certificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

1. Decedent's Name (First, Middle, Lu **Physician** Rudolph P.M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Prince George's 6713 McDonough Terrace Bowie 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 78 Yrs. Hours Min. Sept. 29,1920 Pennsylvania Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2□ F 179 18 0949 Usuel Residence of Decedent 10d. Inside City Limits 10a. Stete 10b County 10c. City. Town or Location Prince George's Maryland Bowie to Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 29721 6713 McDonough Terrace United States Funerai 14. Raca - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 XYas 2 □ No If Yes, Give Yaar or Detes: 1 ☐ Navar Marriad 2 X Married Specify: White 1 Yes 2€No Specify: WWII by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) U.S. Government Systems Analyst 12 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) George Sand Ilsa Bogi 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Maria G. Sand Wife 6713 McDonough Terrace Bowie Maryland 20721 20b. Place of Disposition (Name of cametery, crematory or other place) Jan. 10, Date 1999 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☐ Crametion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Waldorf Maryland The Huntt Crematory 21. Signature of Funerat Service Licensee 22. Nama and Address of Fecility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Pek 1. Entar tha disease of complications that causad tha deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximata Intervai Batween Onset and Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) e. End stage Renal failure
Disto (or es e consequenca of): Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daeth) Lest Due to (or as a consequence of): Physician/Medical Dua to (or as a consequance of): 23b. Did tobacco use contribute to the causs of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown open wound intection þ 24b. Were eutopsy findings available prior to completion of cause of deeth? peripheral varular diseau 24e. Wes en eutopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Death 28b. Time of Injury 28c. tnjury at Work? 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 28e. Pieca of Injury - At homa, ferm, street, factory, offica building, etc. (Specify) 3 Suicide 28f. Location (Streat end Number or Rural Routa Number, City or Town, Stete) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the cause(s) end menner es stated. edicai 29a. Certifier

State Registrar

31. Dete filed (Month, Dey, Year) JAN 15 1999

- Fat H.D. 30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print)

(Check only one)

29b. Signeture end title of cartifier

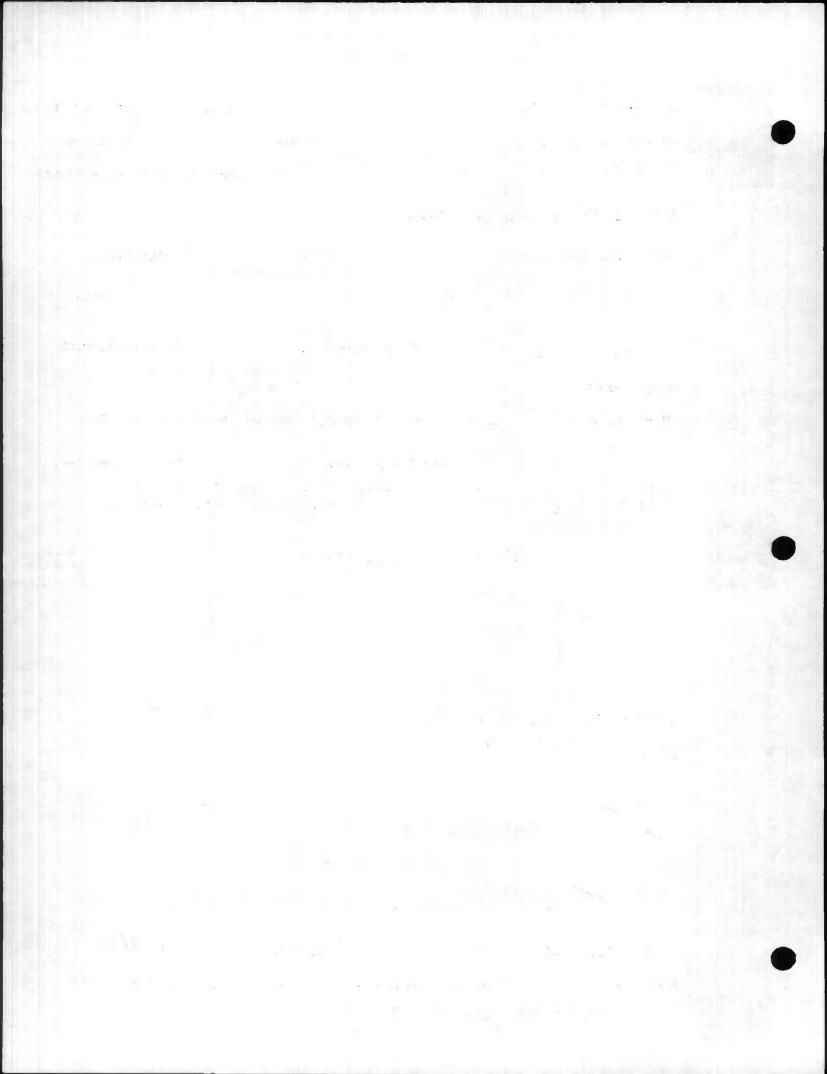


ROINTAN FARAHIFAR M.D. 4000 Mitchile ville road B216 Bowif MD 20716 souls

2 Madical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end pteca, end due to the ceuse(s) end menner stated.

29c. Licansa number

29d. Date signed (Month, Dey, Year)



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Yeer Month 13 1999 4:00 P.M. Jan. Kathleen Mary Sullivan 4b. City, Town, or Location of Death 4c. County of Death 4a Fecllity Neme (If not institution, give street and number) Millersville Anne Arundel Knollwood Manor Nursing Home If Under 24 Hrs. Hours | Min. If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Deys 089 12 1331 1 M 2EXF 75 Months Sept. 18,1923 New York Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 ₩ New York Nassau N. Massapequa 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 335 N. Virginia Ave. 11758 United States 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Maritel Stetus Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. KInd of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Patrick Betsy O'Rourke Goode 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 3202 Burgess Rd. Chesapeake Beach MD 20732 Daughter Eileen Collins 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 18, Date 999 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burlal 2 Cremation 3 Removel from Stete Pinelawn New York 4 ☐ Donetion 5 🖾 Other (Specify) Entombment Pinelawn Memorial Park 22. Name and Address of Fecility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Intervel Between Onset and Deeth 23a. Pal 1. Enter the diseese, or only shock, or heart failure. List or Immediate Ceuse (Finel diseese or condition resulting in death) day 0 Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) unknown Due to (or es a consequence of): resulting in death) Lest

**Physician** /Medical Examiner

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permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, he Medical Expriner must be notified at once.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner attending physician and for use es the burial-transit by the a signed by t P should l Completed certificate has lirector, page 2 page I or Attending Physician: after death. Be 2 this Certification: After

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveileble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 27. Menner of Deeth 28d. Describe how Injury occurred 28c. Injury et Work? Neturel Accident 5 Pending Investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

1 Certifying Physictan: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated.

(Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certifie

30. Nempend address of person who completed ceuse of deeth (Item 23e) (Type, Print)

Blud Arnold MD

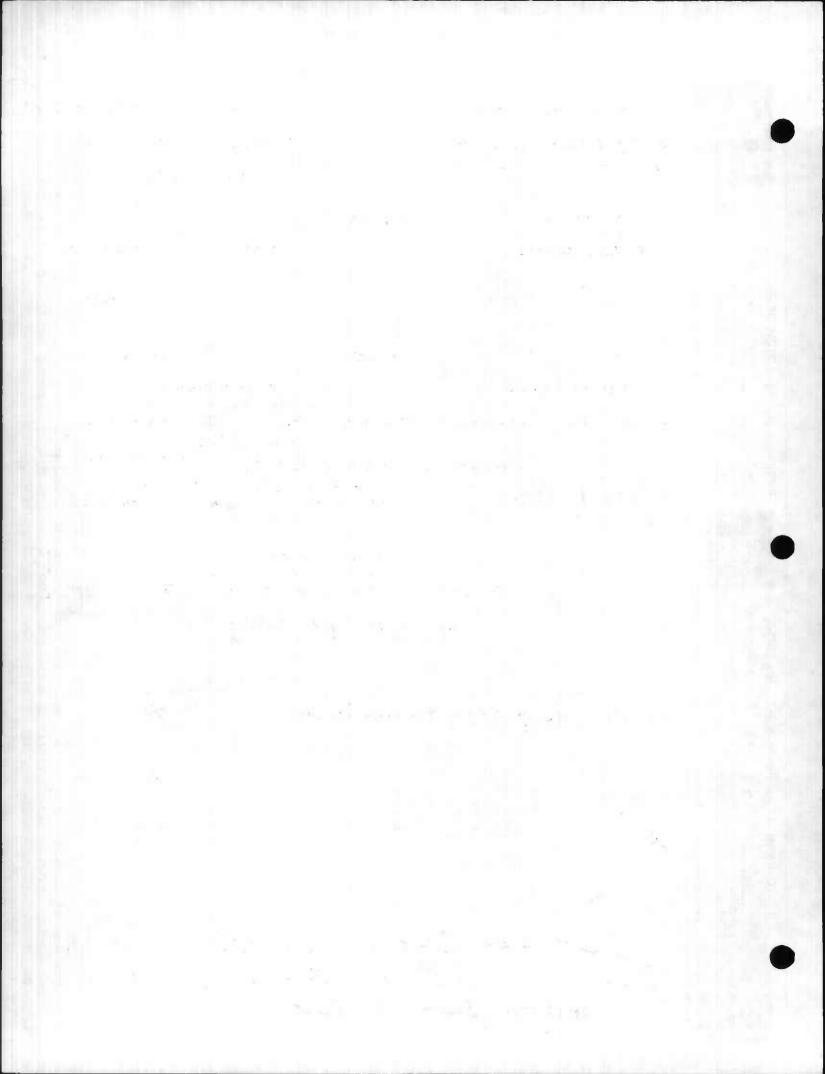
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To the Hospital or Attendit within 24 hours after death. To the Funeral Director: Al completely filled in by the fu

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dey 12 **Physician** 15 W. Frank /Medical 4a Fscility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Ellicott Nursing Republitation
6. Sex / J. Aga (In yrs. last birthdey) ST. Agnes

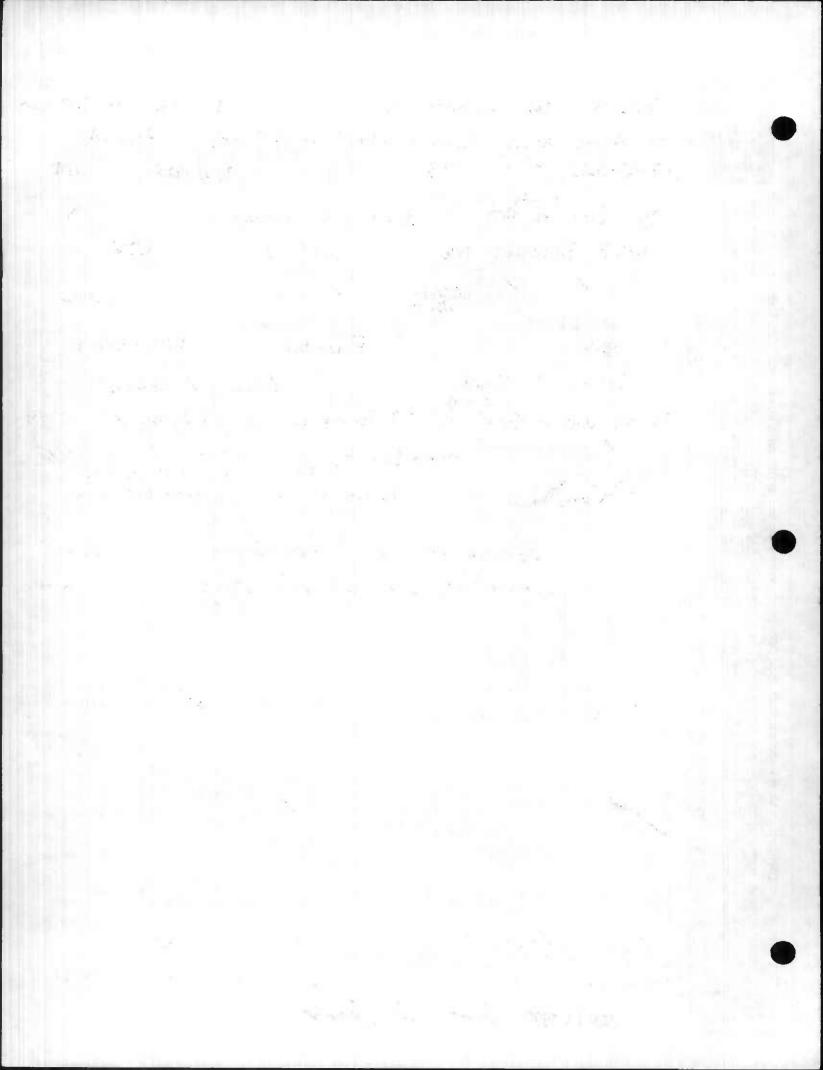
5. Social Security Number Center Howard If Undar 1 Yaar | If Under 24 Hrs. Months | Deys | Hours | Min. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Sex 1 M 2 F Deys 217-22-0225 Director 8/3/1925 Usuel Residence of Decedent the Meryland 10b. County USA 10e. Stete 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 25s-f show the Medical Exaginal must be notified at BALTEMORE 1 Nas 2 No BALTIMORE. Funeral Director MARYLAND 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 1057 PARKSLEY 21223 AVE 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cyben, Mexicen, Puerto Rican, atc.) 12. Wes Decedent Ever in U,S.
Armed Forces?

1 Ves 2 No 1/26/43 - Yeer or Dates: 3/26/46 14. Race - American Indian, 11. Maritel Stetus Bleck, White, etc. filed within 72 hours after 2 Married 1 Never Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: if item 27 is marked other than any Injury or other traumatic event, the Man College (1-4or 5+) construction 1 umbes 18. Mother's Name (First, Middle, Maidan Sumeme) 17. Fether's Name (First, Middle, Last) Be Richard Lillian 19e. Informent's Name/Reletionship (Type, Pnint) (son) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Brimfield Circle 1612 - Elders brg MD 2.
Date 20c. Location - City or Town, Stata William Jr Myn 20b. Plece of Disposition (Neme of cemetery, crematory or other pleca) 20e. Mathod of Disposition
1 □ Burlal 2 ☑ Cremetion 3 □ Removal from State Cotonsville 4 ☐ Donation 5 ☐ Othar (Specify) Crematory

22. Nama and Addragof Fecility 01-15-99 Metro 21. Signature of Funerel Service Licensee FUNERAL Catansville, MD OPTEANS 21228 23a. Pert1. Enter the diseese, or complications that causad the deeth. Do not enter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medicai Immediate Cause (Final diseese or condition resulting in death) Examiner Examiner physician and the bunel-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lsst Due to (or es e consequence of); Box 68760 Physician/Medical Dua to (or as a consequence of): ed by the s Pert II. Other algnificant conditione contributing to death but not rasulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the cause of death? Division of Vital Records, P.O. signed by i 1 Yea 2 No 3 Probably 4 Unknown g 24b. Were eutopsy findings svellable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medicel examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To this 27. Manper of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury st Work? 28d. Dascribe how Injury occurred Naturel Attending 5 Pending r death. 1 Yes 2 No 2 Accident Investigation or Attend efter death Director: Could not be datermined 3 Suicide 28a. Place of Injury - At homa, farm, straet, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Routa Numbar, City or Town, Stete) 4 Homicide To the Hospital ( within 24 hours el To the Funeral D 29a. Certifier 🗹 Certifying Physician: To the best of my knowledga, daath occurred et the tima, dete and plece, end due to the ceuse(s) end menner as atsted. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete and piece, and due to the ceuse(s) end menner steted. 29d. Date signed (Month, Dey, Year) 29b. Signature and titla of certifian raucho 005780 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Frederical Ballimon 21)) ALEJAN DAC 10 2601 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 09, 1999 11:17am Robert Cornell Taylor Jr. 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) University of Maryland Medical Systems Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 5. Social Security Number 1₩ M 2□ F Months Days 11 Yrs 212-31-5911 May 15, 1987 Maryland Usual Residence of Deceden 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 47 Nerbay Road USA 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5th Student Public School 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Name (First, Middle, Last) Robert C. Taylor Sr. Theresa Marie Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Theresa M. Taylor (Mother) 47 Nerbay Road Essex, Maryland 21221 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 ☐ Cremation 3 ☐ Removel from State 1/13/99 4 ☐ Donation 5 ☐ Other (Specify) Mount Zion Cemetery Lansdowne, Maryland 22. Name end Address of Facility 21. Signature of Funeral Service The Caple Funeral Service 5502 Winner Avenue Baltimore, Maryland 21215 complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Hemodichysis 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? Chronic Renal Failure 24a. Was an autopsy 1 ☐ Yes 20 No 25. Was case represent medical examiner? Mid rey 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificata be executed Division of Vital Records, P.O. Box 68760. Attending Physician: 8

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The Funeral Disc.
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**Physician** 

/Medical

Examiner

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Funeral

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**Funeral** 

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Pages 1 and 2 should be filed within 72 hours efter death vent of Haalth end Mantel thygiene.

In it if team 27 is marked other than "natural; or items 23 inty or other traumatic event, the Medical Examination man.

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**Physician** /Medical

Examiner

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To

Certification:

Medical

29a. Certifier

(Check only one)

Baltimore, Maryland 21215-0020

the Marylend

with

State Registrar 29b. Signature and the of-certifier S

\*\*Sertifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number

29d. Date signed (Month, Dey, Year)

D50845

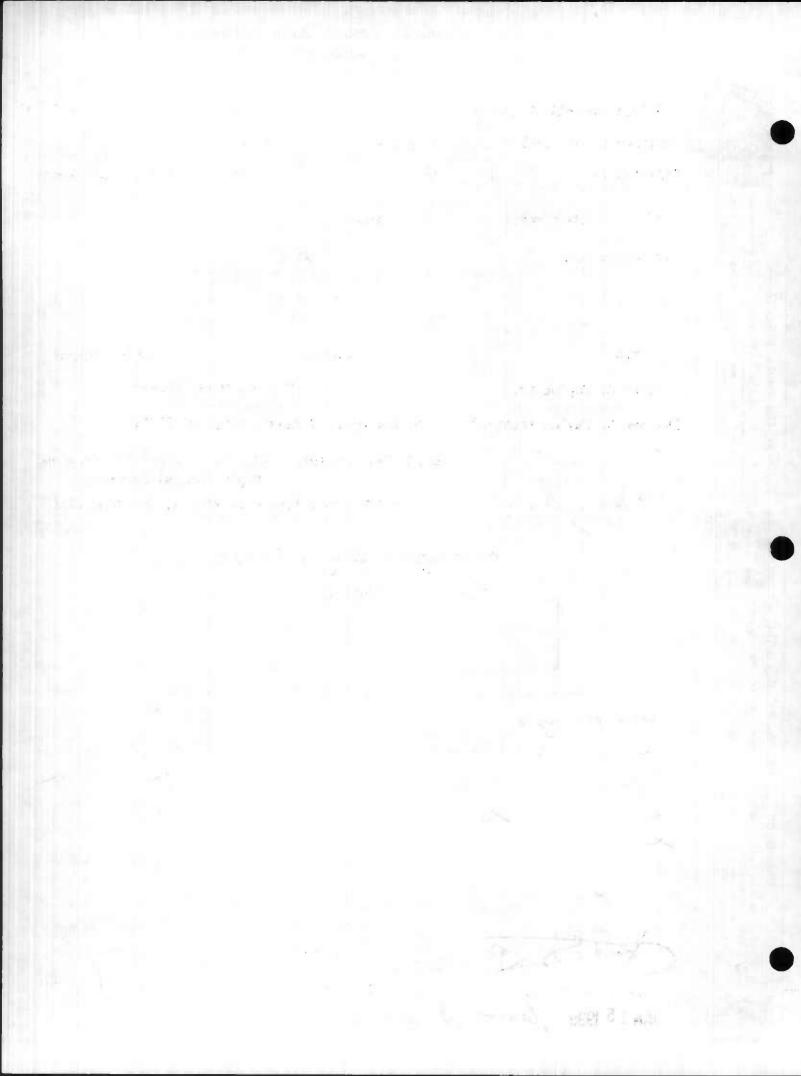
January 09, 1999

who completed sause of death (Item 23a) (Type, Print)

IMMS 22 South Greene Street Baltimore, Maryland 21201 John P. Straumanis. MD 31. Date filed (Month, Day, Year)

JAN 1 5 1999

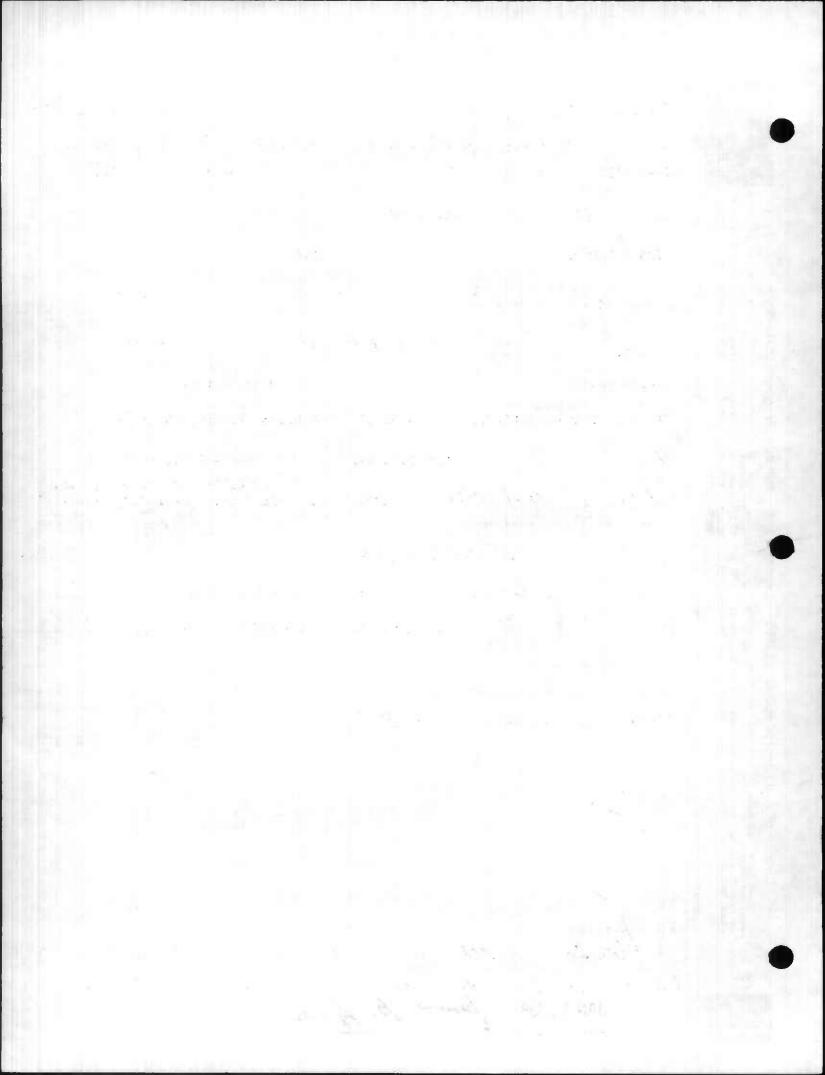
32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Neme (First, Middle, La	ist)	15/11/5		2. Date of De		3. Time of Dea			
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/Medical Examiner	4a Facility Name (If not Institution, give			4b. City, To	wn, or Location of Deat	4				
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23.0	2725 WALBROOK			21216		USA				
1 0	11. Marital Status	12. Was Dacedent Eva Armed Forces?	ar in U,S. 13.	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicer	igin? (Specify Yes or No	14. Race - A	Amarican Indian, White, etc.			
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Mental  Brked o  atic eve  To Be	GEORGE TRAYHAM				MARY TRAYH	AM				
	19a. Informant's Nama/Relationship	(Type Print)	10h Mail	ing Address (Street and Number			te Zin Code)			
0 0 0	CLARENCE TRAYHAM		100000000000000000000000000000000000000	1 KIRKWOOD RD.						
Health em 27 other tr			20b. Placa of Disp		Date	20c. Location - Cit				
nent of H int: If Ite iry or of	20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐		cemetery, cre	ematory or other place)	Date	20c. Location - Cir	y or Town, State			
ury o	4 Donation 5 ☐ Other (Speci	fy)	KING MEM	• PARK	1-15-99	BALTIMORE	E, MD			
Department of He Important: if Item any injury or othe once.	21. Signature of Funeral Service Lice	nsee	2	2. Name and Address of Facili	TY PHILLIPS	ELIMEDAT HO	OME TO A			
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and the same	222 Part   Enter the diseases or con	collections that sourced the				BALTIMORE,	MD 21217 Approximete			
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physician end s the burial-trensit edical Examin	Sequentially list conditions	U	e to (or as a conse							
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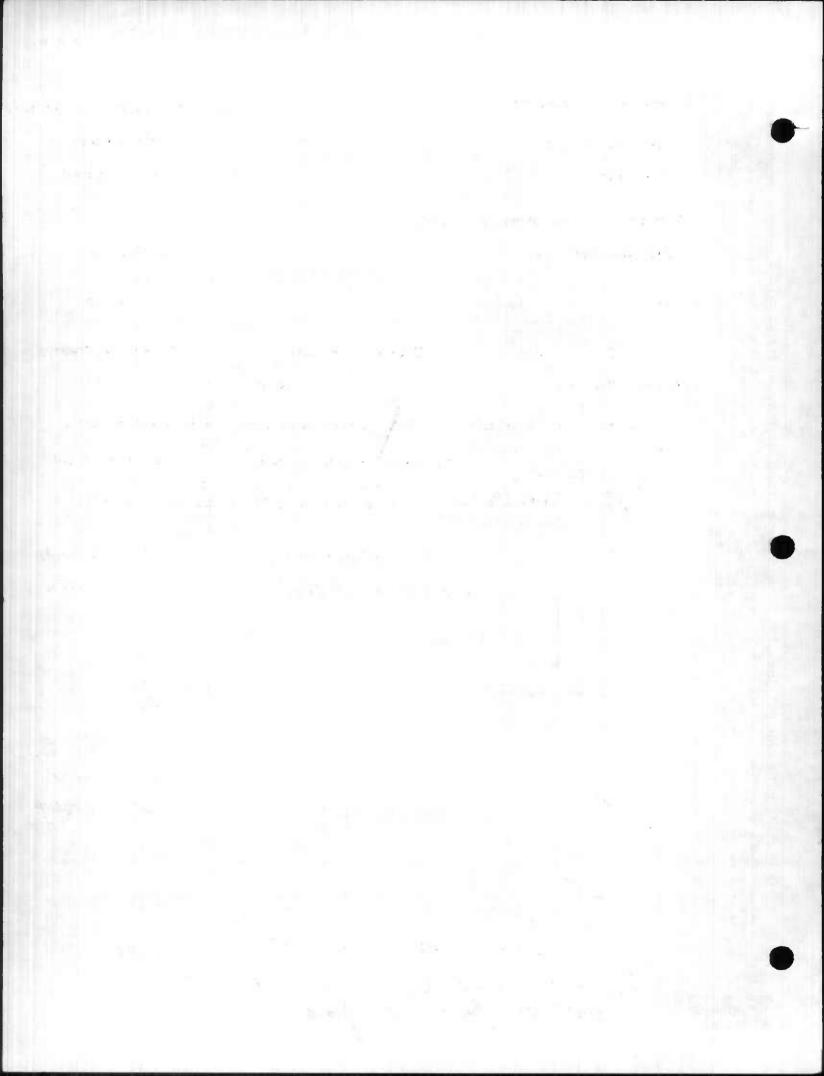
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth **Physician** Mary Emma Thackeray 11:40 A.M. 8 1999 Jan. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Prince George's Bowie Health Center Bowie If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min 1 M 25 F Yrs. Director 577 01 1885 83 Feb. 5, 1915 Maryland Usuel Residence of Decedent with the Maryland 10a State 10h. Counts 10c. City. Town or Location 10d. fnside City Limits r 28a-f show Yes 2□No Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? r than "natural", or items 23s or the Medical Examiner must be a 8306 Chestnut Ave. 20715 United States permit. Peges 1 and 2 should be filed within 72 hours effer death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23 any Injury or other traumatic event, the Mexical Examiner must Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 ☐ Yes 2 ♣ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 2 No Specify: Specify: White p XX Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 College (1-4or 5+) Telephone Company Telephone Operator 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Barbara Fries Charles Baumann 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16120 Pond Meadow Lane Bowie Maryland 20716 Katherine Ryon Daughter Jan. 12, Dete 1999 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Ascension Church Cemetery Bowie Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heer feiture. List only one ceuse on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) Medastatic gastric Caner /Medical Examiner 4 months Gastre outles obstruction Examiner and I-transit that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) physician a the buriel-Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): attending pt signed by the a d be deteched f 23b. Did tobacco use sontribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown ρ 24b. Were autopsy findings available prior to been si Completed 24a. Wes en eutopsy completion of cause of death? The law certificate has t director, page 2 s 1 Yes 2 2 No 1 Yes 22 No Hospital or Attending Physician: 25. Wes case referred to medical exeminer?
1 Yes 2 No director Be 28. Piece of Deeth (Check only one) Heal Ho Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 27. Menger of Deeth enter 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 28a. Dete of Injury (Month, Dev Year) 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: A 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifie MD and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 30. Neme 20715 MO 4000 Mitchuri

State Registrar 31. Dete filed (Month, Day, Year)

JAN 15

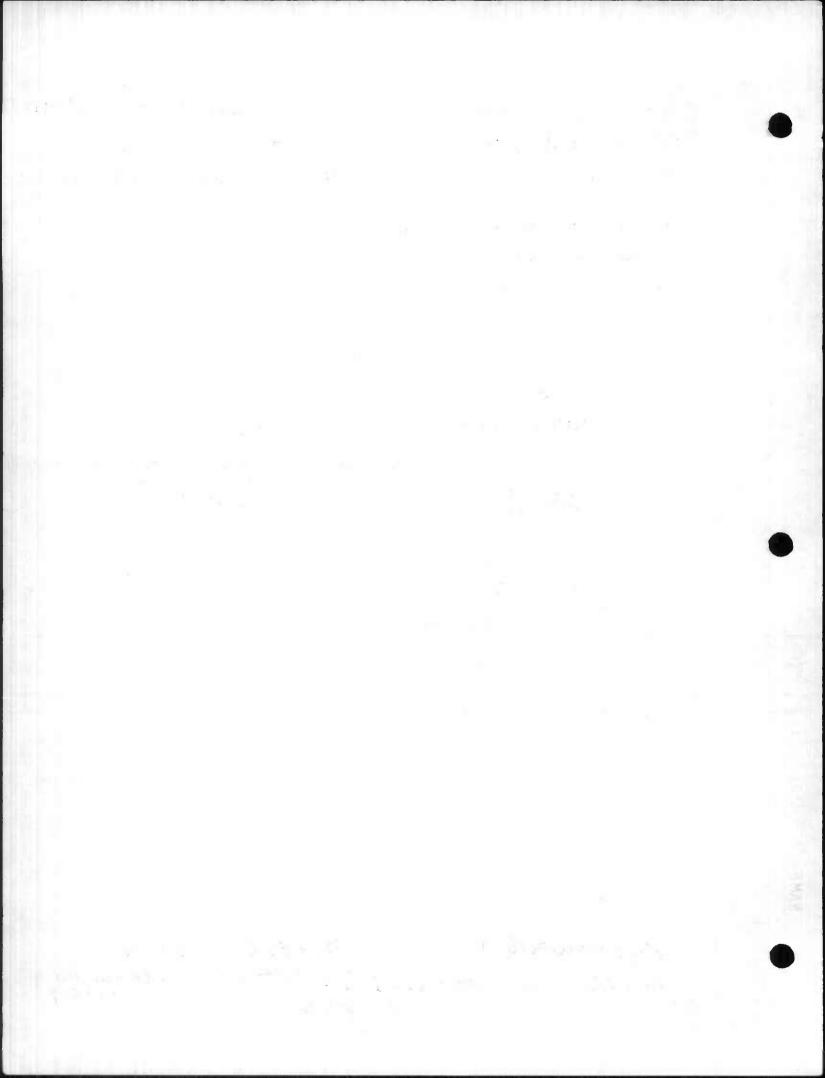
32. Registrer's Signeture



# Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 2 per M.D G-767 1/15/99 reb 1. Decedent's Name (First Middle Last) 2. Dete of Deeth Jan . 11, 1999 3. Time of Death **Physician** Jordan Williams /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St AGNES HOSPITAL BAITU If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Sociei Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys 16 1□M 2\ F Months Yrs. 216-53-8314 Director September 26,1998 Maryland Usuel Residence of Decedent the Merylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-1 show traumstic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? with 7814 Edgewood Avenue 21122 USA Funeral filed within 72 hours after deeth Hygiene. 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No White Specify: g 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) N/A Infant N/A 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) 8 12 should be fi and Mental H is marked of Joseph Williams Nicole Μ. Messenger 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 is m any Injury or other traum sonce. Joseph S. Williams - Father 7814 Edgewood Avenue, Pasadena, MD 21122 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 D Burlel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) Glen Haven Cemetery Jan. 15 Glen Burnie, Maryland 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 plications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, one cause on each line. 23e. Pert1. Enter the disease, or comshock, or heart fellure. List only Physician /Medical Immediate Cause (Fine) disease or condition resulting in death) 22 hrs. Examiner BRONCHOPUL MONARY DYSPLASIA Physician/Medical Examiner attending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury PREMATURIT 1082 thet initieted events resulting in death) Last NAME: Williams baby GiA Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? OCHONDRO GENESIS 1 Yes 2 No 3 Probably 4 Unknown ò 24a. Wes en autopsy performed? 24b. Ware autopsy findings Completed eveileble prior to completion of cause of death? After this certificate 2 No 1 ☐ Yes 1 Ves 2 No 25. Was case referred to medical exeminer? Be 28. Plece of Deeth (Check only one) Hospitel: 1 Yes 2 No 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 □ Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homleide n 24 hours. the Funeral Dire 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piaca, and due to the ceuse(s) end menner stated. 29e. Certifier Medical To the Fune completely f (Check only one) 29b. Signature end title of certifier 29d. Dete signed (Month, Day, Year) 29c. License number D14955 900 Caton ave Balkinge, nul 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) SANTOS, MD 32. Registrer's Signature JAN 15

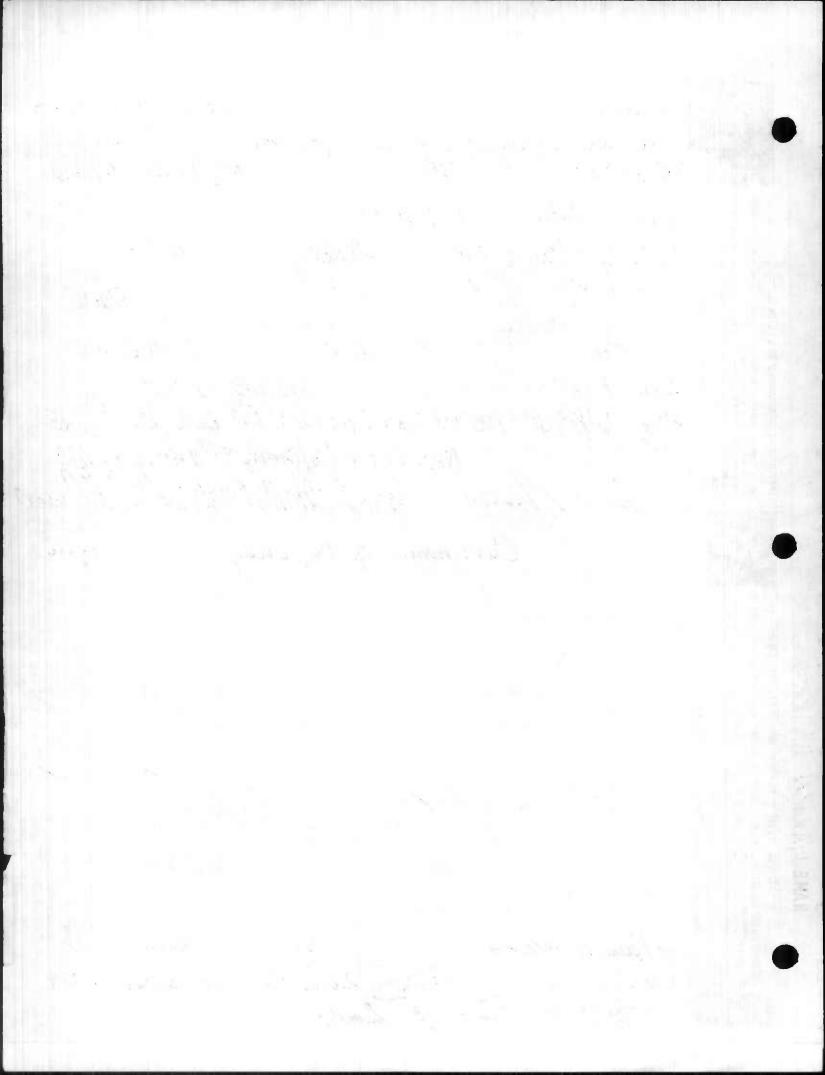
Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

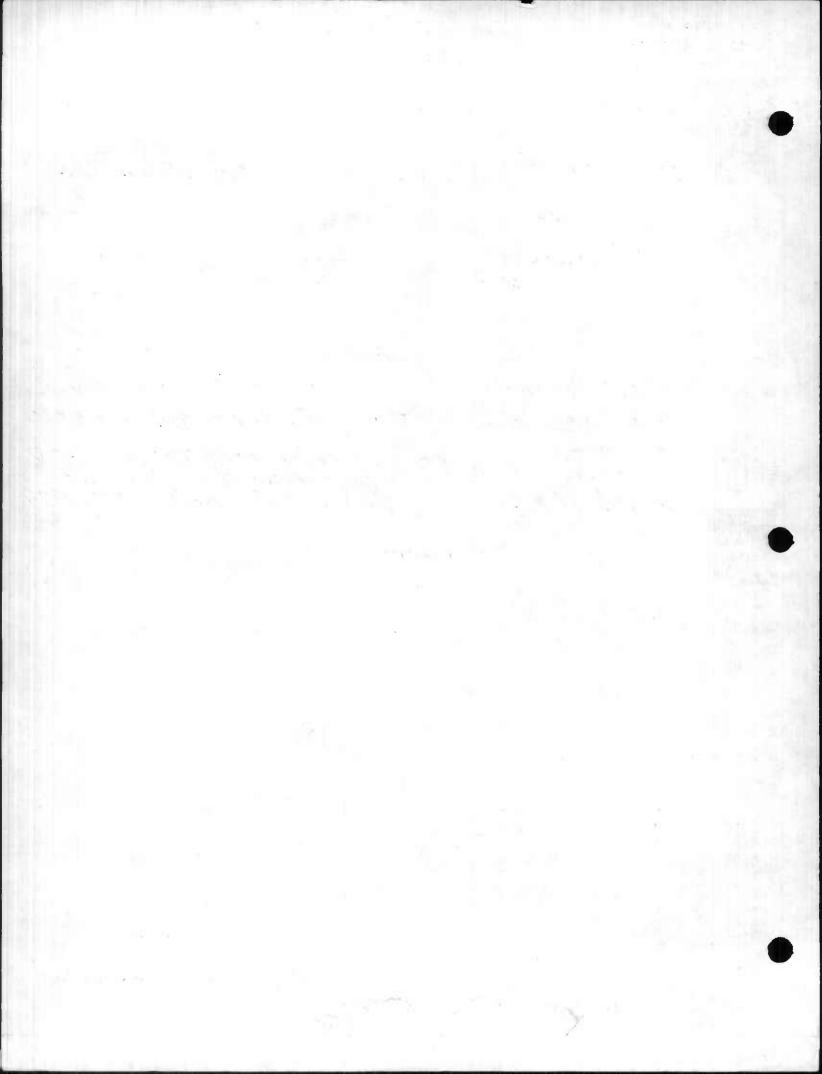
State of Maryland / Department of Health and Mental Hygiene 99 0663

	Certificate of Death	Reg. No.	
	1. Decedent's Name (First, Middle, Last)	2. Dete of Deeth	3. Time of the
Physicia	MADTAN LITIVEC	JANUARY 11, 1999	
/Medic	to English Name (Mant institution give street and number)	or Location of Death 4c. County of De	
Examine			
	SAINT AGNES HOSPTIAL 900 CATON AVENUE BALTIMO		
Funeral	Months Deys Hours N	Hrs. 8. Date of Birth  Ain. Worth, Day, Year 7 10	irthplace (State or Foreign
Director	MAU-AU- MOU 70	11193,1900 1111	rylana
Pu &	Usuel Residence of Decedent  10a. Stete 10b. County 10a 10a City, Town or Location		10d. Inside City Limits
death with the Maryland rms 23a or 28a-f show rms 12a or 20thed at	MA MILLIANDER		1 ☐ Yes 2 □ No
the Mary 7 288-1 sh	S IID VIII OUTINIOLE		10.00
or 20	10e. Street and Number 10e. A DA LIND DUD 10f. Zip Code 21220	10g. Citizen of Whet C	Country?
23a or		U.S.A.	
Rems Institute	11. Maritel Status  12. Wes Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Mar	7 (Specify Yes or No- uerto Ricen, etc.) 14. Reca · Arr Bleck, Wh	nerican indien,
or its		· · · · · · · · · · · · · · · · · · ·	1/00/1
OZ ours e	3 Widowed 4 Divorced Yeer or Detes:	Specify: B	luck
Maryland 21215-0020 d 2 should be filed within 72 hours aff th and Mental hygiene. P? Is marked other than "natural", or traumatic event, in Medical Exert	15. Decedent's Education (Specify only highest grade completed)  Elementery/Sependary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOTruse retired)  USTORIAN	16b. Kind of Busines	s/Industry
n n	(Specify only highest grade completed)  (Give kind of work done during most of life. DO NOT juse retired)		
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and 2 should be filed within 72 hours after asith and Mental Hygiene. n 27 is marked other than "natural", or fre ner traumatic event, the Medical Examins	PODDA MILLES SC - HUSEMM 202 LUNDHURGE	AUP. BOHO, MA	21110
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mit. Peges 1 ar partment of Hea portant: If Itam 2 y Injury or other	4 Donetion 5 Other (Specify)	tery Daitimore	11110.
permit. Peger Department or Important: If I any injury or pace.	21. Signature of Experal Service Licensee	1- CIDONI HOME	P.A.
SSESS	Jeword Land Still Explisite	DATE CANTE	m1 2129
	23a. Pert Information the disease, or complications that caused the death. Do not enter the mode of dying, such as can show or heart failure. List only one cause on each line.	diac or respiretory errest,	Approximete
Physician	show, or heart failure. List only one ceuse on each line.		friterval Between Onset and Deeth
/Medical	Immediate Ceuse (Final disease or condition Carcinoma 2 The Li	4 44 0	1 year
Examiner	resulting in deeth) a.	roug	17
	Due to (or es e consequençe of):		
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certificate be executed ding physician end iss as the burial-transit	Ceuse (Diseese or injury that initiated events resulting in deeth) Lest  Due to (or es e consequence of):		
attending p	d		
0 00	Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco use contribu	ite to the cause of death?
The law requires that the ste hes been signed by th page 2 should be detach		1 Yes 2 No 3	Probably 4 Donknown
quire on si		24e. Wes en eutopsy performed?	. Were eutopsy findings available prior to
w re			completion of ceuse of deeth?
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n: The			- 103 ZEINO
Attanding Physician: The law in death. sctor: After this certificate hes to by the funeral director, page 2 s	exeminer?	Deeth (Check only one)	
£ ==	10 165 20 100 10 Inpatient 20 EN/Outpetient 30 DOA 40 Nuisir	ng Home 5 ☐ Residenca 6 ☐ Other (St 28d. Describe how injury occurred	pecify)
ding Phys h. After this funeral d	27. Manner of Deeth 28a. Dete of Injury 28b. Time of Injury at Work?		
trending Ph death. ctor: After thi y the funeral	2 Accident investigation M 1 Yes 2 No		
or Attender des Director	3 Suicide 4 Homicide  6 Could not be determined  28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or City or Town, Stete)	Rural Route Number,
s afte			
2 5 2 2 2		elece, and due to the ceuse(s) and menner	as steted.
Ho 124 Fu Fu	29a. Certifier (Check only emet)  2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death of end menner steted.	occurred at the time, date and placa, and d	lue to the cause(s)
	29b. Signature and title of certifier	29d. Date signed (Mo	onth, Day, Year)
->-0	Karring Arylana 38543	January 1	1, 1989
V	20 Name and address of paleon was formulated assure of death (Nam 02a) (Time Driet)	January 1.	
50	30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)	African dlastal	21229
	11 Date fleet (Month Day Your) 22 Designation of Caton Avenue on	of proof may all	
Stat	31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signature	,	



99-0059-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. JAMES L. WILLIAMS State of Maryland / Department of Health and Mental Hygiene ITEMS: #23 PART I, 27 PER MEO G767 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** MMES 1999 JANUARY 05 2:13 A /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SECOURS HOSPITAL BON BALTIMORE If Under 24 Hrs. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** 142 M 20 F 213-30-770 Usual Residence of Decedent Yes Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exeminer must be notified at 1 Pres 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 234 Funeral as Decedent of Hisp Yes, specify Cuban, 12. Was Decedent Ever in U,S. Arryed Forces? 1 ☑ Yes 2 ☑ No W Yes, Give Yeer or Dates: Race - American Indian Bleck, White, etc. Rema anic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.) 11. Meritel Stetus hours after 1 Never Married 2 Merried "natural", or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. College (1-4or 5+) AMPAGA Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Majden Sumame) permit. Pages 1 and 2 should be filk.
Department of Health and Mental Hy
Important: If item 27 is marked oth
eny Injury or other traumatic event Be THANIE NER 19a. Informant's Name/Relationship (Type, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, TORY 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Pate cemetery, crematory or other place) 1 Burial 2 Ofemetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of uneral Service Licenses 23e. Part I Frier the disease, or complications that caused the death. Do not enter should be heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final CHRONIC LYMPHOCYTIC LEUKEMIA disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner certificata be executed physician and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Due to (or es a consequence of) signed by the a P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably de Unknown by Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 XYes 2 No Yes 2□ No certificate Division of Vital Hospital or Attending Physician: 24 hours efter death. director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ◯X DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer 1 (X) Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident eral Director: A 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 05, 1999 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vennis 111 Penn Street, Baltimore, Maryland 21201 NO 31. Date filed (Month, D Day Year) 32. Registrar's Signature State Registrar

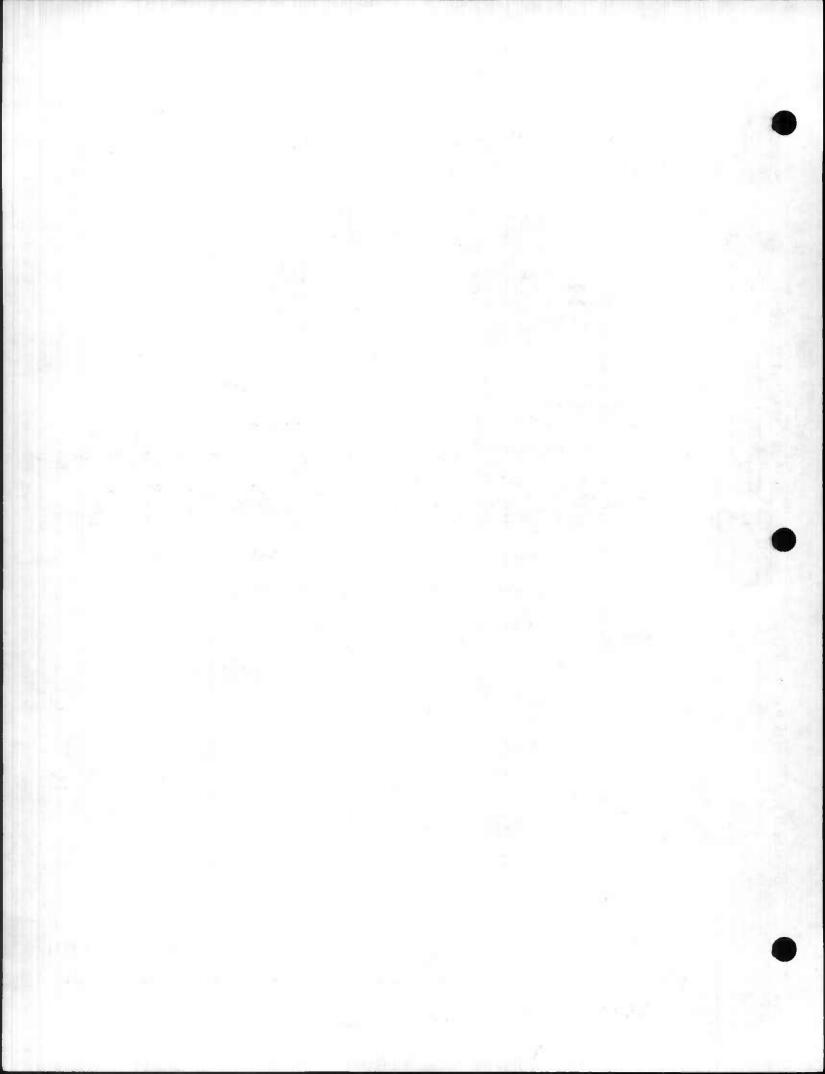


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State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical	Decedent's Name (First, Middle, La Ruby D. Weber	st)			2. Date of Do Month	Day	1999 Yeer	3. Time of Death			
Examiner	4a Facility Name (If not institution, give NORTH ARUNDE)	1) 0		4b. City, Town, o	DURNIE		^	UNDEL			
Funeral Director	5. Social Security Nurhber 6. S 217–20–8944		s. last birthday) If Un Yrs. Month	der 1 Year   If Under 24 Hi ns Days Hours Mi	s. 8. Date of Bi	irth		ce (State or Foreign			
show adat	Usual Residence of Decedent  10a. State 10b. County  MD	N/A 10c. C	City, Town or Location	timore City			100	d. Inside City Limits			
r death with the Maryla Name 23a or 28e-f show at must be notified at uneral Director	10e. Street and Number 201 Warren Avenu			Zip Code 21230		10g. Citizen of What Country? United States					
020 un atte	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Dorvorced	12. Was Decedent Ever in Armed Forces?  1  Yes 35 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? pecify Cuban, Mexican, Pue	(Specify Yes or Norto Rican, etc.)	1100	14. Rece - American Indien, Black, White, etc. Specify: White				
21215- d within 72 giene, or than 'nat the Medica	15. Decedent's Ei (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed)  College (1-4or 5+)		sual Occupation work done during most of w Fuse retired) Maid	orking	16b. Kind of Bu	usiness/Indu	11.1.1			
B state a	17. Father's Name (First, Middle, Last,					e, Maiden Suman	10)				
yla ould Mannes mile To	John Martin Rade				Kitchen						
Mar d22sh hand r le m marie marie	19a. Informant's Name/Relationship (			ess (Street end Number or I							
- 5902	Annabelle Detress  20a. Method of Disposition		Place of Disposition //	lement Stree	Date Date	T	-				
altimore mit. Pages 1.1 partment of Hu portant. If Hu r Injury or oth	1) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Baltimore										
Departingon any in	21. Signature of Funeral Service Licer	seeVictor P. Doda	Char	les L. Steve East Fort A							
P.O. Box 68760, at the death certificate be executed by the attending physician and etached for use as the burial-transit Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	· PARKINSO	(or as a consequence of	ileace	re Luni	a brea		Onset and Death			
the death cer y the attendin sched for use hysician/A	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlyin	g cause given in Part I.	23b. Did	I tobacco ues co	ntributs to t	the cause of death?			
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aw requires to the second of t						s en autopsy formed?	eveil	e autopsy findings lable prior to pletion of cause eath?			
= F # 8 0					10	Yes 2 No	10	Yes 20 No			
ysicien: The scentificate director, pag	25. Was case referred to medical examiner?	Hospital:/		T.	eeth (Check only	one)					
는 를 를 구	1 Yes 2 YNo  27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	DOA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No		idence 6 Oth how injury occur					
DIVISION C ball or Attending P is after death. al Director: After t ed in by the funera Certification:	3 Suicide 6 Could not b		home, farm, street, fac sify)	dory, office		(Street and Numb own, State)	per or Rural i	Route Number,			
Hospi 24 hour Funer tely fill		yelclan: To the best of my kr niner: On the basis of examinand manner stated.									
within To the comple	29b. Signature and title of certifier	TECHNISM	29c. License number		29d. Dete signe	d (Month, Di	ay, Year)				
m	& Onesc	Cr	mb	1245149		JANUA	RY 1	5 1999			
PEI)	30. Name and address of person who	completed cause of death (No. 301 408 PITA	CHEN B	urnie	ms	21	061				
State Registrar	31. Date filed (Month, Day, Year) JAN 15 1999	32. Registrar's Sign	A lan								

WEBER, RUBY



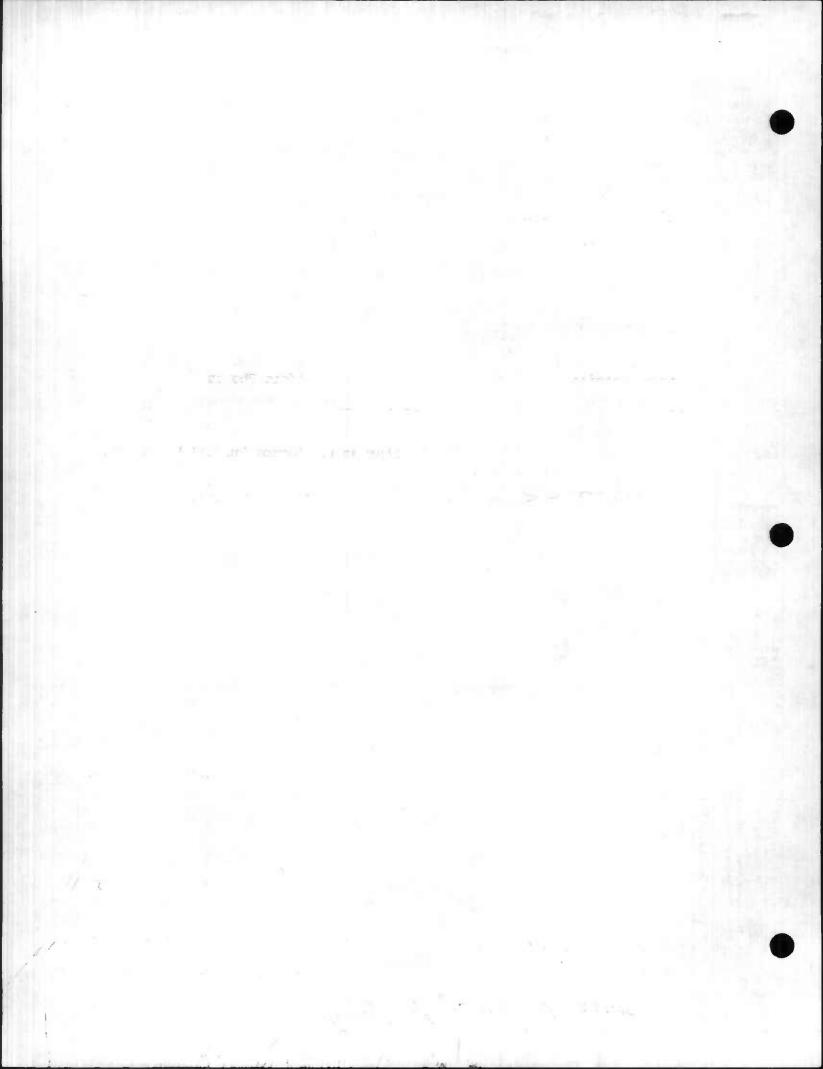
State of Maryland / Department of Health and Mental Hygie

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	Funeral Director
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Insportant: If item 27 is marked other than "natural", or flering 23s or 28s-4 show my injury or other traumatic avant, or Medical Exercise must be notified at

			Cen	tificate of	Death	Re	g. No.		00000				
<b>D</b>	1. Decedent's Name (First, Middle, La					2. Date of Death Month	Day	Year	3. Tima of Death				
Physician /Medical	Warren A. Watkin	S				JANUAR		1999	1843 P				
Examiner	4a Facility Name (If not institution, give				4b. City, Town, or L		4c. County						
N.D.	NORTH ARUNDEL	HOSPITAL	to an allowed and	If Under 1 Yea		JRNIE	ANNE		NDEL				
Funeral Director	236-02-2510	Sex 120 M 2□ F 7. Age (In yrs 30	: last birthday) Yrs.	Months Days		8. Date of Birth (Month, Day, April 11	, 1968		place (State or Foreign htry) WV				
and	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Loc	ation				1	Od. Inside City Limits				
vith the Mary or 28a-f sho be notified		ne-Arundel	Glen	Burnie					1 ☐ Yes X No				
23a or 2	10e. Street and Number 243 Woodhill Dri	ive		10f. Zip Code 21	061	10	g. Citizen of \ US		try?				
21215-0020  d within 72 hours after death with the Manyland giane. In than "natural", or florms 23a or 28a-f show. In the death Employment Employed.	11. Marital Stetus  XXX Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 以 Yes 2 □ No If Yes, Give Year or Dates:	11	/es Decedent of Yes, specify Cui	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Bleck, White, etc.  Specify: Black						
1 21215-0 ed within 72 ho ygiene. Per than 'naturi It, the Medical Completed	15. Decedent's E (Specify only highest gro		16a. Decede (Give k	ent's Usual Occu	upation e during most of work ed)	king 1	6b. Kind of B	usiness/Inc	dustry				
2121 a within piane. r than n	Elementary/Secondary (0-12)	College (1-4or 5+)					T.	liah '	School				
	12 17. Father's Name (First, Middle, Last	4	Mus	ic Teac		ne (First, Middle, M.			501001				
Maryland 2 d 2 should be filed h and Mental Hygi 7 is marked other traumatic avant, To Be Co	Warren Watkins				Addie 1								
Magage Manage Ma	19a. Informant's Name/Relationship ( Addie Watkins /	Type, Print)  Mother	The second second		eet, Char		City or Town, V 253		Code)				
O Se Se Se Se Se Se Se Se Se Se Se Se Se	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremetion 3  4 ☐ Donation 5 ☐ Other (Speci	Removei from State		atory or other pla	ial Gardens		0c. Location	City or To					
Baltim parmit. Pig Department Important: any injury attes.	21. Signature of Funeral Service Lice		a, Jr. 22.	Name and Addi	ress of Facility  L. Steven	s Funera	1 Home						
	23a. Part1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Physician /Medical Examiner	immedieta Cause (Finat disease or condition resulting in death)	a. John		Thimle	pey bolyn			1	Interval Between Onset and Death				
death certificate be associted estimating physician and ad for use as the bunal-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and initiated events Due to (or es e consequence of):												
× 5 5 ×	d.												
	Part II. Other significant conditions of	contributing to death but not re	23b. Did tobacco use contribute to the c			A/1							
s been s should						24a. Was an perform	autopsy ed?	av	ere autopsy findings eilable prior to impletion of cause death?				
T 0 -8 -						1.2 Yes	s 2 No	16	Skes 2□ No				
ystclen: The ystclen: The secreticate director, pa	25. Was case referred to medical exeminer?				26. Place of Dea	th (Check only one	)						
- K 50 5	1 X Yes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient	ALAUUA		ome 5 Resider	nce 6 Oth	er (Specif	(Y				
	27. Manner of Death 1 Death 2 Accident S Pending Investigatio		28b. Time of Injury	28c. inj W	ury at ork? ] Yes 2   No	28d. Describe how	w injury occur	red					
DIVISION  I or Attending I after death. I Director: After id in by the func	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec		et, fectory, office	9	28f. Location (Str. City or Town,	eet and Numl State)	ber or Rura	il Route Number,				
Hospi 24 hou Funer taly fill	29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Example 1	nysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death etion and/or inve	occurred at the testigation, in my	time, date and place, opinion, deeth occur	, and due to the car rred st the time, da	use(s) and me te and place,	ennar as s and due to	tated. tha cause(s)				
within 2 To the comple	29b. Signeture and title of certifier	29	d. Date signe	d (Month,	Day, Year)								
	1 Theodore	M. Je of us	.M.E	J	ANUARY	04,	1999						
6	30. Name and address of person who	completed cause death (tte	m 23a) (Type, P	111 Per	nn Street,	, Baltimo	re, Ma	rylar	nd 21201				
State Registrar	JAN 1 5 199	32. Registrer's Sign	g.	Sport									

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Name (First, Middle, Last)	or Death	2. Dete of Death							
Physiciai /Medica	Mary E. Wojcicky		Jan. 7,	Dey Year 1999	8:08pm					
Examine	An English blome /// not institution when street and need and seed and	4b. City, Town, or L Brooklyn		4c. County of Death						
Funeral Director	212-44-1815 10 m 2RF 52 Yrs.	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Dey, ) Dec . 27	9. Birth <i>Cou</i>	placa (Stete or Foreign ntry) MD					
Maryland -f ahow	Usual Residence of Decedent  10a. State  10b. County  10c. City. Town or Location  N/A  Baltimore	City			t0d. Inside City Limits					
after death with the Manyler or hams 23a or 28a-f ahow minet must be notified at	MD N/A Baltimore  10e. Street and Number 1445 Covington Street  11. Marital Status 1 Never Married 2 Merried 1 Never Married 2 Nerried Never Merried 2 Nerried Never Merried 2 Never Merried 2 Never Merried Never Merried 2 Never Merried Never	21230	100	Citizen of Whet Cou						
5 5 5	If Yes, Give 1 ☐ Yes 2½  Year or Detes:	t of Hispanic Origin? (Sp Cuban, Mexican, Puerto Mo Specify:	pecify Yes or No- Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.  Specify: White						
d within 72 hours aff glene. or than "nature", or y ne. Model Even	Elementary/Secondary (0-12) College (1-4or 5+)	done during most of worl	king	Sb. Kind of Business/In						
0.00	10 0 Quality Co 17. Father's Name (First, Middle, Last) Jacob A. Brethauer	18. Mother's Nem	e (First, Middle, Ma y Kelly		ouring					
Peges 1 and 2 sh nant of Health and inft; if item 27 ia m iny or other traum	19a. Informant's Name/Relationship (Type, Print) Frank R. Matkins, III / Son 19b. Mailing Address (S	Baltimo	City or Town, State, Zine MD 212							
	20a. Method of Disposition  15 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)  20b. Pleas of Disposition (Name of cemetery, cremetory or other place)  Paltimore National VA Cemetery Jan. 11, 1999  Baltimore National VA Cemetery Jan. 11, 1999									
permit. Peges 1 al Department of Hee Important: if item eny injury or othe page.	21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and A. Charles L.	Address of Fecility Stevens Fune	ral Home, I		t Fort Avenue e MD 21230					
Physician /Medical Examiner	Due to (or as a consequence of);	Cancer VIR	Liver M	etastaser	Interval Between Onset and Death					
Serificate be associted ding physician end se as the buriel-transit	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									
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+ 00 s			1/2 Yes		obably 4 Unknown					
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ilcien: The lev certificate has rector, page 2			1 ☐ Yes	^	☐ Yes 2 No					
Physicien: this certific ral director.		Othor	th (Check only one) ome 5 Residen	ca 6 ②Other (Spec	(v) Friends					
Affection		Injury at Work?	28d. Describe how		Residence					
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e Hospital 24 hours • Funeral sletaly filled	29a. Certifier  (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner at 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner at a course of the time, date end place, and due to the cause(s) and manner at a course of the time, date end place, and due to the cause(s) and manner at a course of the time, date end place, and due to the cause(s) and manner at a course of the time, date end place, and due to the cause(s) and manner at a course of the time, date end place, and due to the cause(s) and manner at a course of the time, date end place, and due to the cause(s) and manner at a course of the time, date end place, and due to the cause(s) and manner at a course of the time, date end place, and due to the cause(s) and manner at a course of the time, date end place, and due to the cause(s) and manner at a course of the time, date end place, and due to the cause(s) and manner at a course of the time, date end place, and due to the cause(s) and manner at a course of the time, date end place, and due to the cause(s) and manner at a course of the time, date end place, and due to the cause(s) and the course of t									
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Pill	20 Name and address of December 2 Production and delivery of the Control of the C	13/55	/ )	anyasy	7,1799					
State	30, Name and address of person who completed cause of death (Item 23a) (Type, Print)  Out of the complete of t	Craint	lighway	Oto Bur.	megal. 2106/					
Registrar	101175 4000	1/21								

DHMH 16 Ray 6/95

Jakes, in a see of the Lines.

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Deeth 3. Time of Death 1. Decedant's Nama (First, Middla, Last) MILDRED WATKINS 9:12 AM JANUARY 13,1999 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, give street and number) JOHN'S HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Undar 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (Stata or Foraign Days Hours 1 M 2 F Ohio 217-34-9242 Jan. 13,1920 Usuel Rasidence of Dacedent 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits N/A **Baltimore** 1 Yes 2 □ No Md. 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 6418 O'Donnell Street 21224 U.S.A. 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 Yes 2 No If Yas, Give Year or Datas: 1 Navar Merried 2 Marriad 1 ☐ Yas 2 No Specify: Specify: White Widowed 4 □ Divorced 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) 11 Homemaker Own Home 18. Mothar's Name (First, Middla, Maidan Surnama) 17. Father's Neme (First, Middla, Last) Clarence Reisinger Mildred E. McGrandhan 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Judy Alexander/ Daughter 6418 O'Donnell St., Baltimore, Md. 21224 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore-Washington Crematory Laurel, Md. 21. Signature of Funeral Sarvice Mansaa 22. Nama end Addrass of Facility Bradley-Ashton-Dabrowski-Matthews Funeral Home, Ind complications that causad the death. Do not enter the mode of dying, such es cerdiac or respiratory arrast, only one cluse on each line. Approximata intarval Between Onset and Death 23a. Part1. Entar tha disaasa, of com shock, or haart feilure. List only 48 hours Immediate Ceuse (Finel disaasa or condition rasulting in daeth) GASTRO INTESTINAL BLEED Dua to (or as a consequance of): Sequentially list conditions, if any, leading to immadiate causa. Entar Undarlying Causa (Diseese or injury that initiated avants rasulting in daath) Last Due to (or as a consequence of): Due to (or es e consequenca of): 23b. Dtd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24z. Was an autopsy performed? completion of cause of death? 25. Was casa rafarrad to medical axaminer? 28. Place of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Manner of Deeth 28b. Tima of 28c. Injury et Work? 1 Naturel 2 Accidant 5 Pending 1 ☐ Yas 2 ☐ No Invastigation 6 Could not be determined Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Sulcide 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homlcide

**Examiner** that the death certificate be axecuted Box 68760. Division of Vital Records, Attending ò

physician and the burial-transit 50 980 certificate ha this Aftar r deeth. à 24 hours aftar Funeral Directletely filled in b Direc To the Hosp within 24 ho To the Fune completely fi

**Physician** 

/Medical

Examiner

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Funeral

by

Completed

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**Funeral** 

Director

r than "naturel", or Itema 23a or the Medical Examiner must be

7 is marked other traumatic event, i

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m eny Injury or other traum page.

**Physician** 

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Certification:

edical

29e. Certifier

(Check only one)

29b. Signature and titla of certifiar

the Marylend r 28a-f show

death

2 should be filed within 72 hours after and Mentel Hygiene.

altimore, Maryland 21215-0020

State Registrar

1999

Elizabeth fignadath MD

30. Name end eddress of person who complated cause of death (Item 23a) (Type, Print)

32. Registrar's Signatura

oocks

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

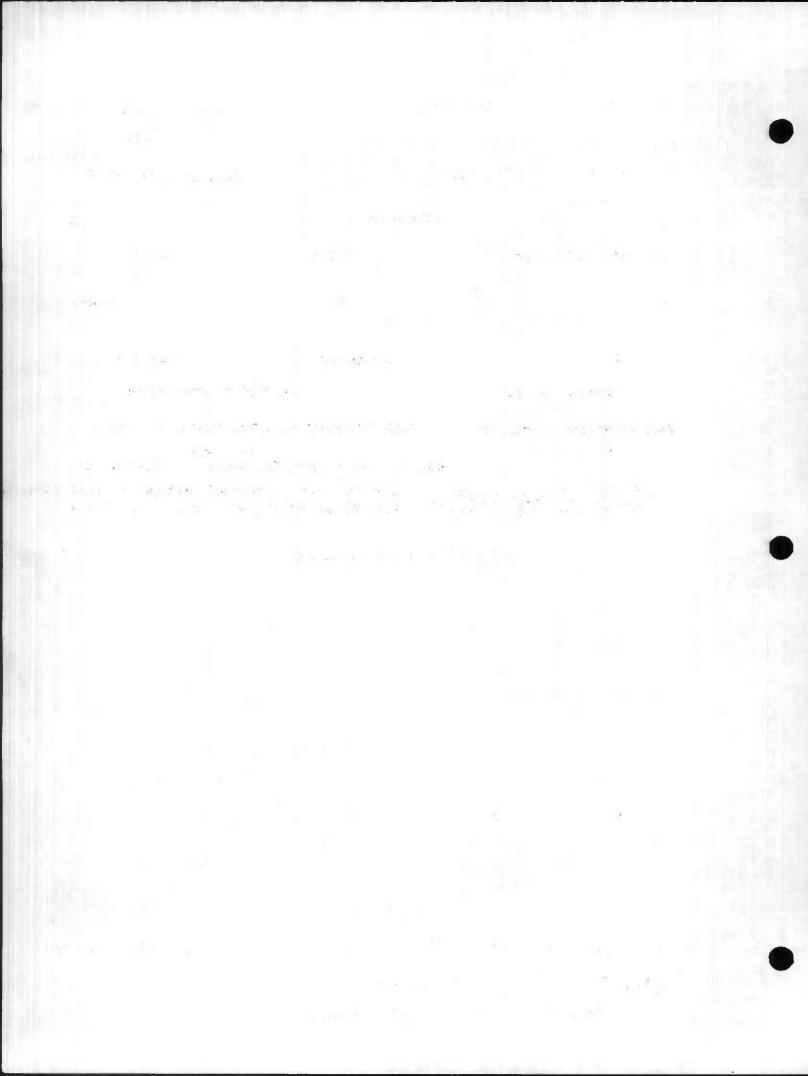
29c. Licansa number

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29d. Data signad (Month, Day, Year)

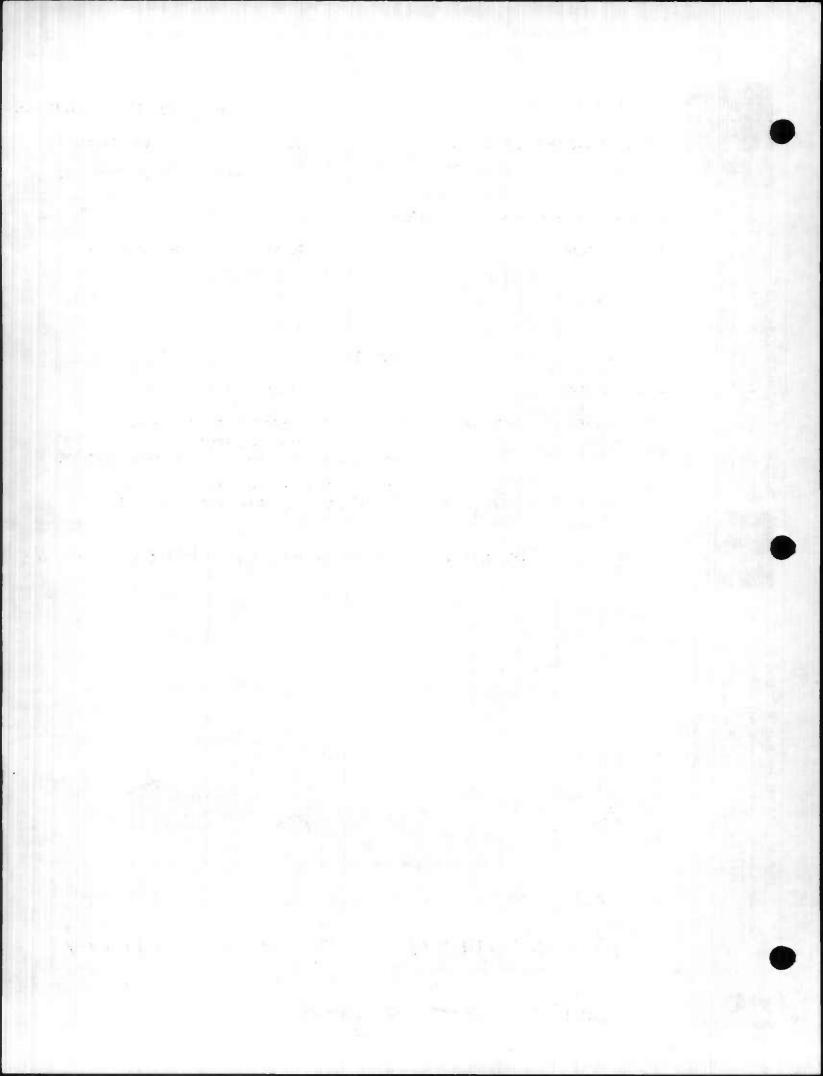
JANUARY 13, 1999

Balto. Md. 21224



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decede	ent's Name	(First, Middle	a, Last)							2. Data of De			3. Ti	me of Death
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aminer	4a Facility	y Neme (If	not institution	n, give stree	et and numbe	r)			4	b. City, Town, or L	ocation of Dea	th 4c. Count	ty of Death		
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eral ctor		Security Nu 22 76		6. Sex 1 ☐ M	2 F 7. /	Age (In yrs. 73	last birthday) Yrs.	If Under 1 Months D		If Undar 24 Hrs. Hours Min.	8. Date of Bi (Month, D Dec. 2	rth a <i>y, Year)</i> 21 <b>,</b> 1925	9. Birth Cou Ma1	iplace (S intry) ry1a:	tate or Foreign nd
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fed at	Mary		Princ	e Geo	rge's		Lanham	cation							Yes 2 No
at be notried		et and Num	ber Ls Lane					10f. Zip Co	ode	20706		10g. Citizen of United		-	
Examiner must be not/led at by Funeral Director	3 🗆 W	ever Marrie	ed 2 Marr	ied 1	Was Decedar Armed Force: I Yes 25 If Yes, Give Yaar or Datas	s? J No		Was Deceden if Yes, specify 1 ☐ Yes 2√	ent of Hispanic Origin? (Specify Yas or No- ify Cuban, Mexican, Puerto Ricen, etc.)  No Specify:			Bio	14. Race - American Indian, Black, White, etc.  Specify: White		
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To Be	Edw	ard F	. King							Anna I	Louise	Stansbu	ry		
If Itam 27 is my or other traum	19a. Info	ment's Na n Whe	me/Reletions		<sub>Print)</sub> Daught	or		Mailing Address (Street and Number or Rural Route Number, 105 Lois Lane Lanham Marylan						ip Code)	
		nod of Disp			Daugne							20c. Location		Town, Sta	ate
	1₹6	Burial 2	☐Cremetion 5 ☐Other (S		oval from Stat		20b. Place of Disposition (Name of cemetery, cremetory or other place) Jan. 18, Lakemont Memorial Gardens					Davids			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Item 5 Per FH Film G767 1-19-99 State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Item: 1 per M.D G-767 1/15/99 reb 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death GERARD-MARIE McGuffie Woel M.D Day Year Month 11:48 pm D. Gerard Wool January 1999 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death N/A Baltimore City SINAI HOSPITAL 5. Social Security Number 215-42-7542 215-45-7545 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours 1 M 2 F Yrs June 26, 1932 Haiti 66 Usuai Rasidenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore City 1X Yes 2 No Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 3315 Pinkney Road USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married ☐ Yes 2 No f Yes, Give 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Haitian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Surgeon/Physician Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) McGuffie Fernande Theophile Woel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) (Dghtr) 917 Windwhisper Lane, Annapolis, MD 21403

20b. Place of Disposition (Name of cematery, cramatory or other place)

Deta

20c. Location - City or Tot Arabella C. W. Popovitch 20a. Method of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns1/11/99 Timonium, Maryland 21. Signature of Funeral Service Sicence of Martin D. Lawson 22. Name and Address of Facility Lawson Mitchell-Wiedefeld Home, Inc 6500 York Road Baltimore Maryland 21212. 23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Interval Between Onset end Death Immediate Cause (Final Pulmonary Embolism 7 days disease or condition resulting in death) Adenocarcinoma Due to (or es e consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Congestive Heart failure 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Drabetes completion of cause of deeth? Yes 2 No 1 ☐ Yes 2 No

**Physician** /Medical Examiner

Examiner

Physician/Medical

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**Physician** 

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Pages 1 and 2 should be fill ment of Health and Mantal Hant: If itam 27 is marked oth jury or other traumatic aven

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altimore, Maryland 21215-0020

physician and s the burial-transit 62 use signed t page 2 s has funeral director, this After within 24 hours after death. To the Funeral Director: Al

requires that the death certificate be exec

Hospital or Attanding Physician:

To the

Division of Vital Records, P.O. Box 68760.

25	25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☒ No			26. Piece of Death (Check only one)							
			Hospital: 1 Inpatient 2	☐ ER/Outpatient	3□	DOA Other: 4	Other: 4 Nursing Home 5 Realdence 8 Other (Spe				
27	Manner of Death  Natural  Accident	5 Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes		28d. Describe how injury occurred			
	3 ☐ Sulcide 4 ☐ Homicide	6 Could not be determined		home, farm, stree	t, fact	ory, offica		28f. Location (Street and Number or Rural Route Number, City or Town, Stete)			

29a. Certifian (Check only one)

🔀 Csrtifying Physician: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) and mannar as stated. 2 Medical Examinar: On the besis of examination end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and titla of certifiar

29c. Licensa number RES-000

29d. Data signed (Month, Day, Year) January 7, 1999

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

Sinai Hospital-Baltimore, Baltimore, MD Amador Subong,

State Registrar

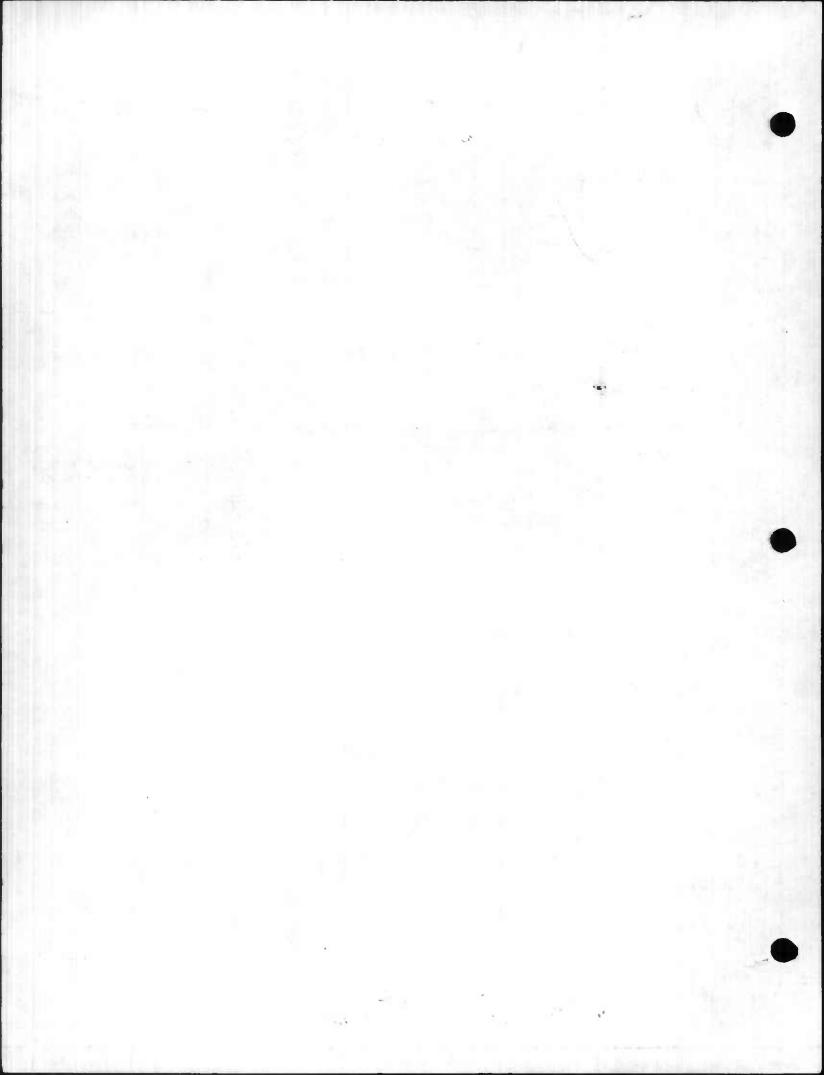
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32. Redistrar's Signature

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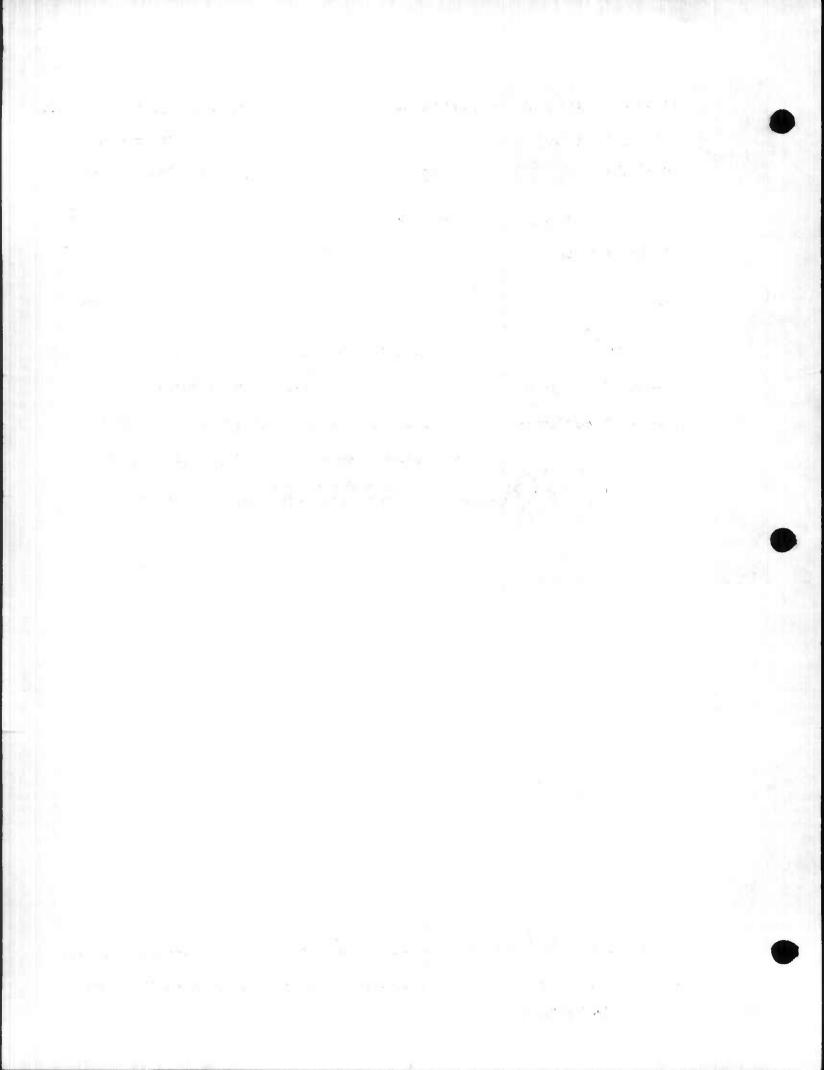
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Registrar



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aryland	dat		Usual Rasidanca d 10a. Stata	10b. County			10c. Ci	ty, Town or Lo	cation				10		City Limits
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Deps moon	any ir			1	X	Ph.	^	Gre		ral Home, St.Hanco		21.750_03	269		
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DIV To the Hospital or A within 24 hours after To the Funeral Direc	eletaly fill	29a. Certifier (Check only one)  1. Certifying Physicisn: To tha best of my knowledga, daath occurred at tha tima, deta and place, and dua to tha causa(s) a 2. Medical Examiner: On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, deta and place, and dua to tha causa(s) a 2. Medical Examiner: On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, deta and place, and dua to tha causa(s) a 2. Medical Examiner: On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, deta and place, and dua to tha causa(s) a 2. Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the tima, deta and place, and dua to the causa(s) a 2. Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the tima, deta and place, and dua to the causa(s) a 2. Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the tima, deta and place, and dua to the causa(s) a 2. Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the tima, deta and place, and dua to the causa(s) a 2. Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the tima, deta and place and the causal and the									causa(s) and ma deta and place,	snnar ss sta snd dua to	ited. tha causa	(s)	
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10			30. Nama and addr	ass of person	who compla	ted cause of	death (Iter	n 23a) (Type, I	Print)						
,			Edward W.	Ditto	, III	M.D	. 2	17 W.	Washingt	on St.	Hagerst	own, MD	2174	0	
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Tima of Death 12:2711 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Secours tospitA BALTIMER & If Undar 24 Hrs. 8. Dete of Birtl 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 8. Dete of Birth (Month, Dey, Year 12/18/1939 Birthplece (State or Foreign Country) 6. Sex 1₩ 2□ F Months Deys 59 Yrs. South Carolina 249-62-2387 Jsuel Residence of Deceden 10b. County 10c. City, Town or Location 10d. insida City Limits NIA 1 X Yes 2 □ No Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 805 Spedden Street u · S · a · 14. Race - American Indien, Bleck, White, etc. 21216 11. Maritel Stetus 12. Was Decedent Ever in U.S. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Merried If Yes, Give Yaer or Detes 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorcad 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Tow Motor Operator Venition Blind Co. 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Sumeme) Henry Jamison Rosa Fogle 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Lois Jamison / Wife 805 Spedden St., Baltimore, Maryland 21216 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Deuriel 2 □ Cremation 3 □ Removal from Stete Loudon Park Cemetery 01/18/99 Daletmore, ...., 22. Name and Address of Fecility The Derrick C. Jones Funeral Hm. Maryland 21215 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensee 4611 Park Heights Ave., Baltimore, Maryland 21215 23e. Pert1. Enter the disease, or complications the caused tha death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause of such line. Approximete Intervei Betw Immediate Cause (Fine) ema disease or condition resulting in deeth) Due to (or as a consequence of): significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 P Unknown 24b. Wera eutopsy findings available prior to completion of causa of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

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The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

or Attending Physician:

**Physician** 

/Medical

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10a. State

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Department of Important: If any Injury or

other traumatic event. Director

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21215-0020

Baltimore, Maryland

Examiner Physician/Medicai p Completed

25. Was case refarred to madical examiner?

1 Yes 2 THNO

27. Mennes of Deeth

1 Naturel

2 Accident

3 Suicide

4 Homicide

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceusa (Diseese or Injury that initiated events resulting in deeth) Lest

5 Pending

Investigation

6 Could not be

Other: 1 Impatient 2 ER/Outpetient 3 DOA

26. Flace of Deeth (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work?

1 Yes 2 No

28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

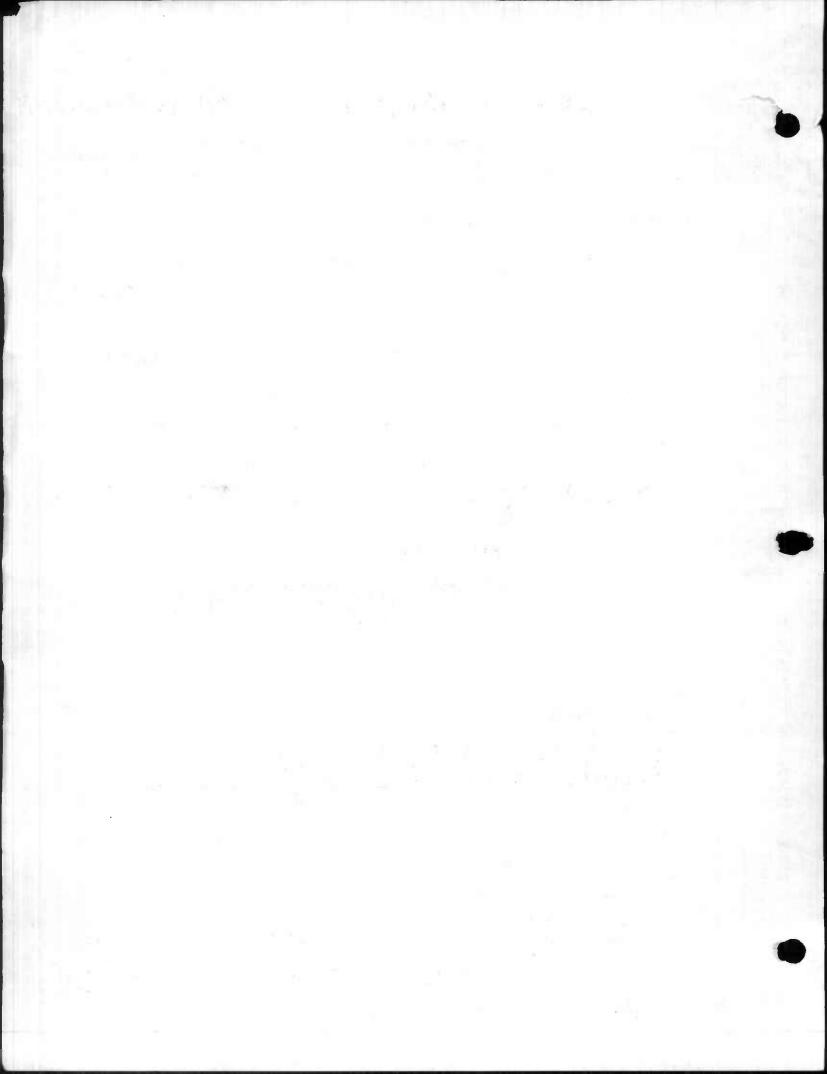
1 Sertifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29b. Signeture and title of contiller 29c. License number

Hospitel:

29d. Data signed (Month, Day, Year)

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State Registrar

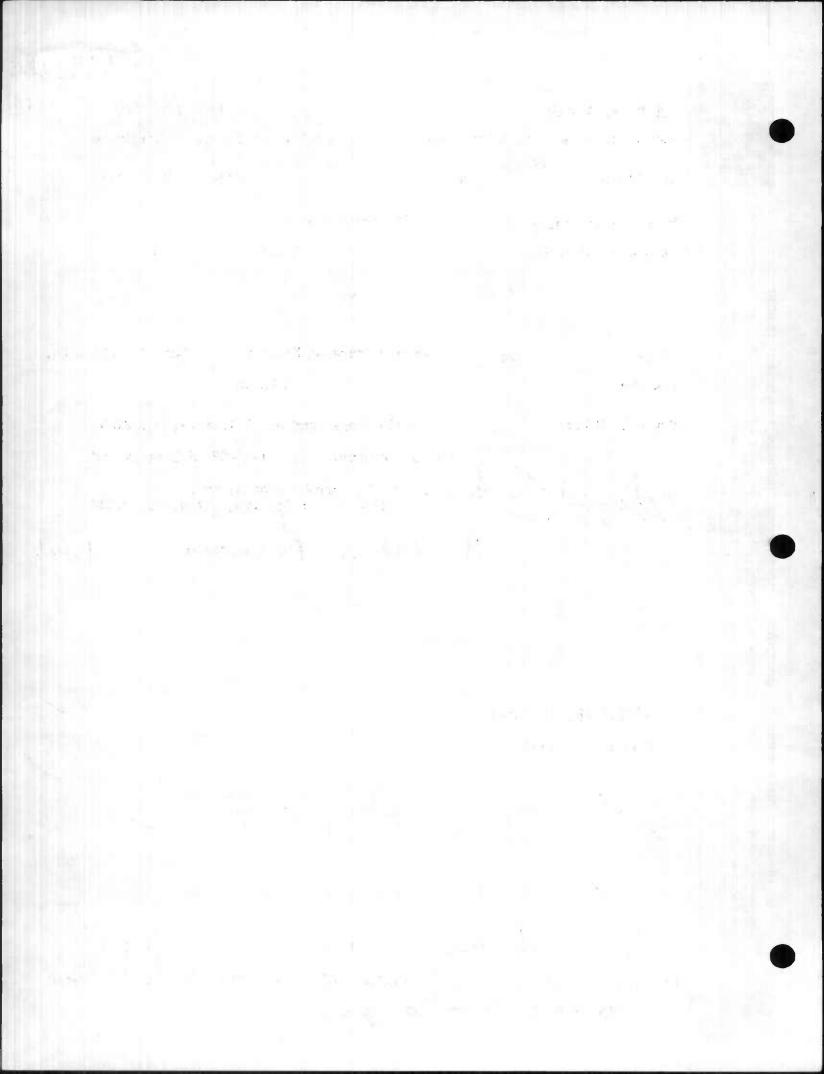


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7.20 ATL 99 1 CLYDE M. MOHLER /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Forest Haven Nursing & Conc. Home Baltimore County Baltimore If Under 24 Hrs. If Under 1 Year 6. Sex M 2 F 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days Hours Yrs. Director 167-14-5848 Usual Residence of Decedent Jan. 30,1923 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental hygiene.

ant: If item 27 is marked other than "naturel", or items 23s or 28s-f show ury or other traumstic event, it a Marical Evantinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Baltimore County Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 9420 Joppa Pond Rd. 21234 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1/CYYes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes X2 No Specify: Specify White p 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Data Processing Manager Schmidt Baking Co. 12 yrs. 6 vrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be Unknown Unknown 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bryan L. Mohler 9420 Joppa Pond Rd. Baltimore, Md. 21234 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 Bural 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Department of Important: If any Injury or Metro Crematory Inc. 1+14-99 Baltimore, Md. 21. Signature of Funeral Service Idoens 22. Name end Address of Facility E. F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087
Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximata Interval Between Onset and Death that caused the deeth. **Physician** NEUMONIA /Medical SPIRATION Immediate Cause (Final Week disease or condition resulting in death) Examiner Examiner that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): 60 USB signed by the a 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Onknown HEIMERY þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed RKINSONS page 2 has 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificata or Attending Physicien: 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funerai 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending after daath. 1 Yes 2 No 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rure! Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral C Hospital Medicai 29a. Certifier La Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. within 2 To the the 29b. Signeture and title of certifier 29c. License number 29d. Date; signed (Month, Dey, Year) 0 lelian 13 weller 30-Name end address of person who completed ceuse of death (Item 23a) (Tyrge, Print) AKHANI, EIGHTS HYE IASNEEM 7220 TARK 31. Date filed (Month, Dey, Year) JAN 1 6 1999 32. Registrar's Signeture State

**DHMH 16 Rev 6/95** 

Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Defe of Death 3. Time of Death

	ı
Physician	ı
/Medical	ı
Examiner	I
Examine	I

The law requires that the deeth cartificate be executed physicien end s the burial-transit for use es signed by the a been s hes he 2 certificate or Attanding Physician: director this After this funeral n 24 hours efter deeth.

Ne Funeral Director: Al deeth. Hospital

1. Decedent's Name (First, Middle, Last) Pay, 19 999 JAMOBRY 3:47 PM GENEVIEVE S. VICK 4a Fecility Neme (If not institution, give street end number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hours Min. 8. Date of Birth (Month, Pey, Year)
Mar. 25,1925 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months Deys 10M 20F Mar. Yrs. 425-36-7460 73 Mississippi Director Usual Residence of Decadent the Marylend 10b. County Baltimore 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f show the Medical Examiner must be notified at Baltimore County Maryland 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours efter death with Hygiene. 21236 7 Sipple Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: White à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b, Kind of Business/Industry 7 is marked other than traumetic event, the Ma Elementery/Secondary (0-12) Coilege (1-4or 5+) 12 yrs. N/A Homemaker Homemaking-Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, page. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Samuel Hardy Lawrence Mary Reese 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7 Sipple Avenue Baltimore, Maryland 21236 Harry P. Vick (Husband) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removal from State Gardens of Faith Cemetery 1-16-99 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) ure at Puneral Service Licanses 22. Name and Address of Facility al Home 7401 Belair Rd. Baltimore, Md. 21236 ale onald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** GANGRENE - BOTH FEET /Medical immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequenca of):
PERIPHERAL VASCULAR DISEASE Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Division of Vital Records, P.O. Box 68760 Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 Unknown CORONARY ARTERY DISEASE à 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy Completed 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 2 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury of Work? Certification: 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide edicai 29a, Certitier 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.



To the To the

State Registrar 31. Date filed (Month, Dey, Year)

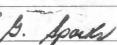
JAN 1 6 1999

29b. Signature and title of certifier

(Check only one)



30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

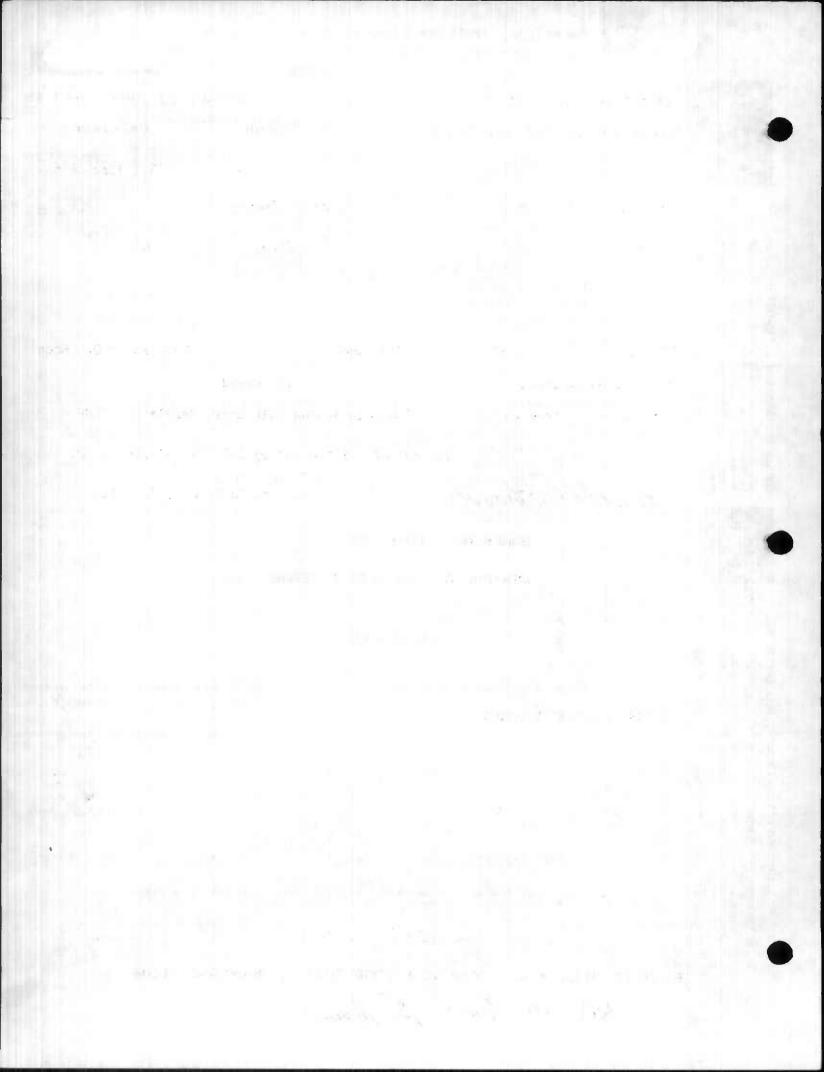
29c. License number

D 30263

7620 YORK ROAD TOWSON, MARYLAND 21204

29d. Date signed (Month, Dey, Year)

-15-99



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔎 🔾 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month rnest JANUARY 1999 4e. Facility Neme (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Maath Baltimore MARY LAND GENERAL 5. Sociel Security Number 6. Sex T. Age (In yrs. lest birthday) It Birthplece (State or Foreign Country) 229-20-1498 10 M 20 F Months Yrs. a 10b. County 10c. City, Town or Location 10d. Inside City Limits Ballinore 1 Yas 2 □ No 10e. Street and Nymber 10f. Zip Code 10g. Citizan of What Country? U.S. A 21215 Tal 12. Was Decedent Ever in U,S. Armed Forcas? 1 SYas 2 □ No If Yes, Give Yaar or Datas: Rece - Amarican Indian, Bleck, White, etc. 11. Maritel Status 1 Never Merried 2 Married 1 ☐ Yes 2 No Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) laborer Stee 10 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Shaw Sarah ames 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Routa Num per, City or Town, Stete, Zip Code) Baldo Location - Gity or Town, Ste WITE 20b. Plece of Disposition 20e. Method of Disposition Date Gity or Town, Steta 1 Burial 2 Cremetion 3 Ramoval from State

22. Name end Address of Facility
Douglass Funeral
1701 Uc Cullo h

permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene Hyportant: If item 27 is marked other than "natural", or ther any injury or other traumatic event. In Medical Event **Physician** 

**Physician** 

/Medical

Examiner

10a. Sfata

3819

**Funeral** 

Director

28a-f show

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Items 23a

event, the Medical Examiner must be notified at

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Funeral

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Completed

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the Maryland

Baltimore, Maryland 21215-0020

RNESTS HAM

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/Medical Examiner

ettending physician end for use es the bunel-transit

signed by the et

page 2 s

certificate

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After

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Certification: To

Medical

diseese or condition resulting in deeth) Physician/Medical Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last

25. Wes case referred to medical exeminer?

1 Yes 2 No

27. Menner of Deeth

1 Neturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Immediate Cause (Finel

4 Donetion 5 Other (Specify)

21. Signature of Funerel Service Licenses

MYOCAR DIAL Due to (or es a consequence of): Due to (or es e consequenca of):

Due to (or es e consequença of)

1 Inpatient 2 ER/Outpetlent 3 DOA

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of

Part T. Enter the disease, or complications that support the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each fine.

Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes an eutopsy performed?

24b. Were eutopsy findings evalleble prior to completion of cause of deeth?

Approximete Interval Between Onset end Death

1 Yas 2 No

1 ☐ Yes 2 ☐ No

26. Plece of Deeth (Check only one)

ervi

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury et Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred et tha fime, date end pleca, end due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) end menner steted.

29b. Signeture and fitle of cartifiar 29c. Licanse number

28e. Dete of Injury (Month, Dey Year)

29d. Data signed (Month, Day, Year)

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

Kenneth Geh, M.D. HOSPI GENERAL DMARYLAND

Registrar

filed (Month, Dey, Year)

JAN 1 6

5 Pending

investigetion

6 Could not be determined



**DHMH 16 Rev 6/95** 

Records,

Division of Vital

Hospital or Attending Physician: The law requires

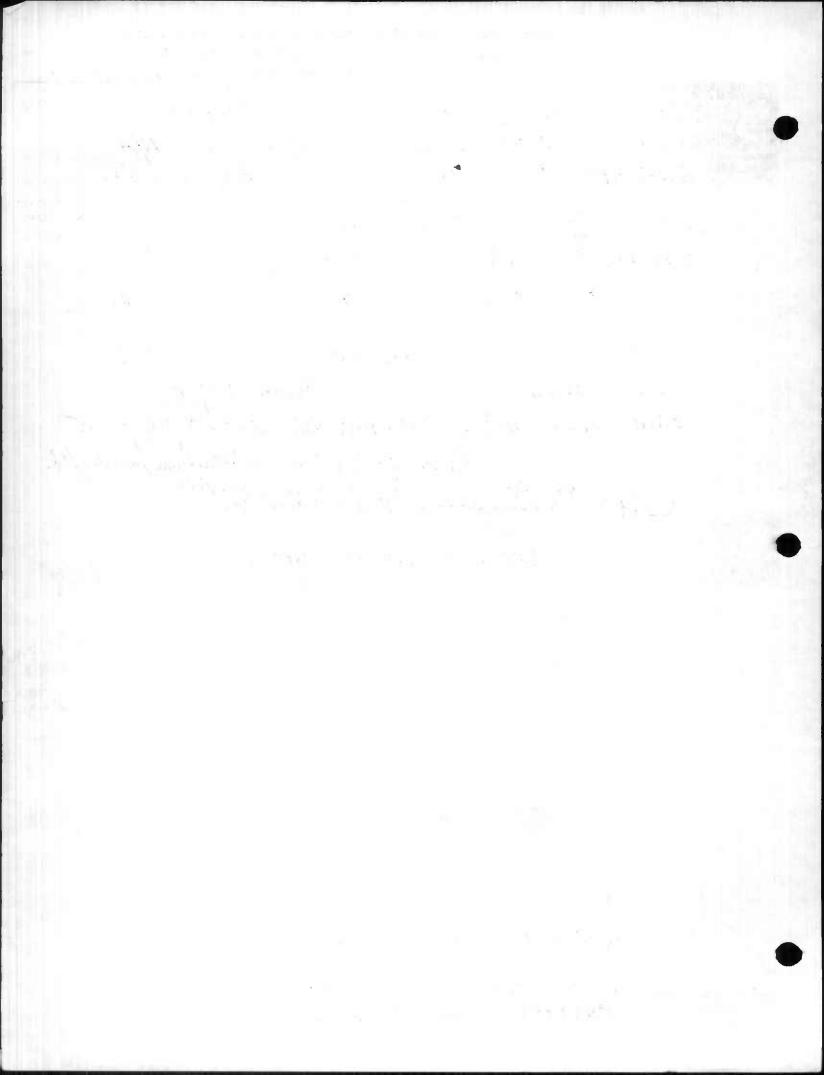
that the death certificate be executed

P.O. Box 68760.

To the Hospital or Attendinwithin 24 hours after death.
To the Funeral Director: Aft completely filled in by the fu hours after death.

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State



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer PAMELA ALSTON 1999 10:40/tm Jan 16 4c. County of Deeth 46. City Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) BALTIMORE UNION MEMORIAL NA HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. 7. Age (In yrs. lest birthday) Dete of Birth (Month, Dey, Year) Birthptece (State or Foreign Country) 5. Social Security Number 6. Sex Months Deys Hours 1 M 2 XF 39 03-22-59 MD 215-76-3988 Usuat Residence of Decedent 10c. City, Town or Location 10d. Instde City Limits 10b. County 10a Stete 1 Ves 2 □ No MD NA Baltimore 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number USA 21205 520 N. Ellwood Avenue 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 12. Was Dacedent Ever In U.S. Armed Forces? X Never Married 2□ Married 1 Yes 2 No 1 ☐ Yes 2 ☐No Specify: Specify: Black ff Yes, Give Yeer or Detes: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Bustness/Industry 15, Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elemantary/Secondery (0-12) Production Line Lever Brothers Inc. 12th Grade 18. Mother's Name (First, Middla, Maiden Surname) 17. Father's Name (First, Middle, Last) Coleman Johnnie Alston John Н. 19b. Mailing Address (Straet end Number or Rural Routa Number, City or Town, State, Zip Code) 21213 19a. Informent's Neme/Retetionship (Type, Print) 1654 Cliftview Avenue Baltimore, Maryland Alston Johnnie 20b. Place of Disposition (Neme of cemetery, crematory or other placa) 20c. Location - City or Town, State Data 20e. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Loudon Park Cemetery 01-20-99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Baltimore, Maryland 21202 21. Signeture of Funeral Service Licensee WM.C.March FH 1101 E. North Avenue remand D 9 mound 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feiture. List only one ceuse on each tina. Approximeta tntervel Between Onset end Deeth Metastatic Breast can cer Immediete Ceuse (Finat disease or condition rasulting in death) ears Due to (or es e consaquance of) Sequentially list conditions, if any, leading to immediata causa. Enter Undarlying Couse (Disaasa or tnjury that initiated events resulting to deeth) Lest Due to (or as e consequenca of): Due to (or es e consequence of): 23b. Did tobacco use contributs to the cause of death? Pert II. Other significant conditions contributing to deeth but not rasulting in the underlying ceusa givan in Pert I. 1 Yas 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of daeth? 24a. Was an eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 No 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 28d. Dascribe how triury occurred 28b. Time of

**Physician** /Medical **Examiner** Physician/Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

**Director** 

with the Maryland

permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumstic event, the Medical Example must be nuttied at once.

altimore, Maryland 21215-0020

ettending physician and for use as the burial-transit The law requires that the death certificate be executed signed by the e been signatured this certificate hes or Attending Physician: Affer death. filled in by the f efter

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Certification:

edical

Division of Vital Records, P.O. Box 68760.

25. Was cese referred to madical 1 Yas 2 No 28e. Date of tnjury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Death 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be 28e. Place of Injury - At home, ferm, streat, fectory, office building, etc. (Specify) 3 ☐ Suicide 4 \[ \text{Homicide} TX Cartifying Physicien: To the best of my knowledga, daath occurred at the time, data and piece, end due to tha ceuse(s) and mennar as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, daath occurred at the time, data end piace, and due to the ceuse(s) end menner stated. 29a. Cartifier

29b. Signeture end title of certifier Nan Ni, MD

(Check only one)

29c. License number 29d. Dete signed (Month, Dey, Year)

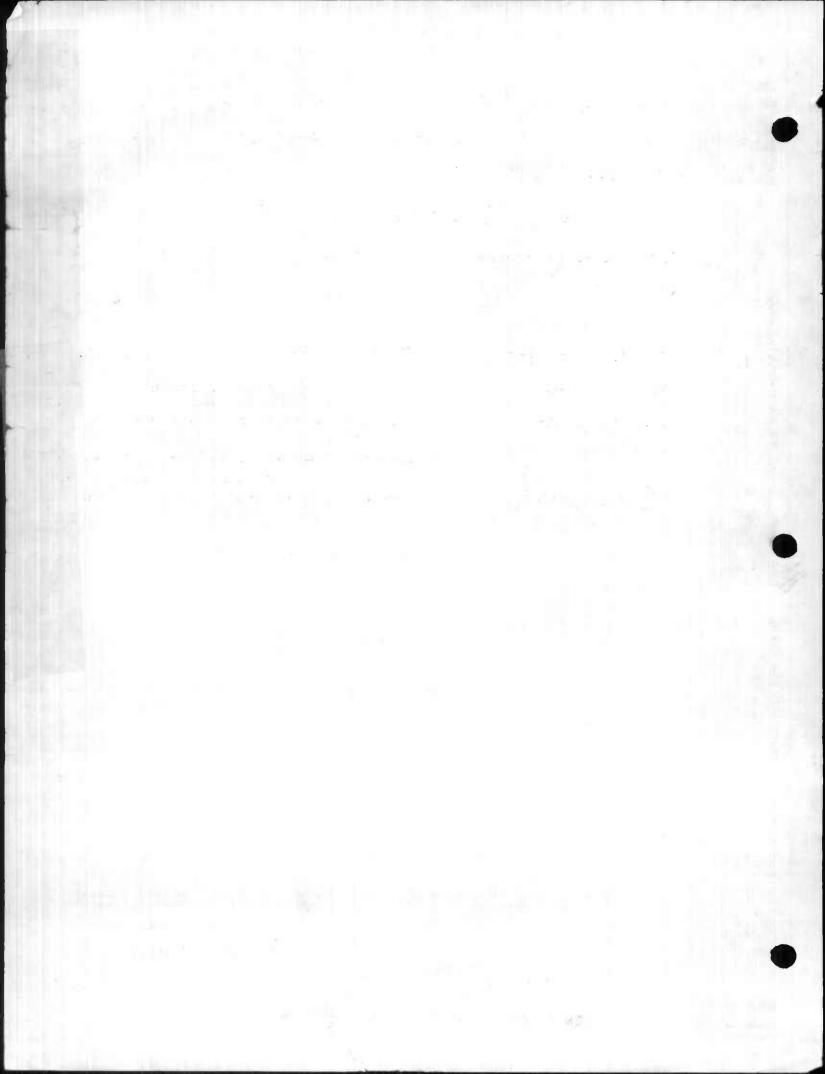
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30. Name and eddrass of parson who complated cause of death (ttem 23e) (Type, Print)

201 E. University PKway Union Memorial Hospital 31. Dete filad (Month, Day, Year) ND 32. Registrar ignatura

State Registrar

To the Mospital within 24 hours of To the Funeral Completely filled



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month vsician ARHITAGE MARCELLA R JANUARY 6:45 AN Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE CHURCH HOME N/A If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 X F 336-24-7723 Yrs. 82 Director Sept 24, 1916 Illinois Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits NOU the Manyla r than "natural", or items 23a or 28a-f if the Medical Examiner must be notified MD N/A 1 Yes 2 No Director Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 101 N. Bond Street 21231 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. Bleck, White, etc. hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White à 3 twidowed 4 □ Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. ther than Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Pages 1 end 2 should be fill ment of Health end Mentai Hant: If Item 27 is marked out Be Joseph Marshall Katherine Reuter 19e. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2: Department of Health er Important: If Item 27 is any injury or other trau /daughter 14 S. Beechwood Ave Mary Ellen Bean Catonsville, MD 21228 Jan 20 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 🖾 Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory Catonsville, MD 22. Name end Address of Fecility
Connelly Funeral Home of Dundalk 21. Signature of Funerel Service Licensee oft Co 7110 Sollers Point Rd 21222 23a. Part1. Enter the discrete, or complications that caused the death / Do not enter the mode of dylng, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical need Algheimer's Disease
Due to (or es a consequence of): Advanced Examiner be executed buriel-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) Box 68760. physiclan Physician/Medical the deeth certificate the Due to (or es e consequence of): for use as as signed by the a P.O. I Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records. þ been si 24b. Were eutopsy findings evalleble prior to completion of ceuse of deeth? 24e. Was en autopsy Completed performed' The law 1 Yes 2 No 1 TYes 2 No certificate Division of Vital 25. Wes cese referred to medicel examiner? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 Inpatient 2 □ ER/Outpetient 3 □ DOA this To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the lunera 27. Menper of Deeth Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred After 1 Natural 5 Pending Investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month. Dev. Year) Cougain 80001 D16619 1999 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD. 21231 C. VERGARA - SOARES ST. 101 N.BOND 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture JAN 1 9 1999 Registrar

DHMH 16 Bey 6/95



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0679

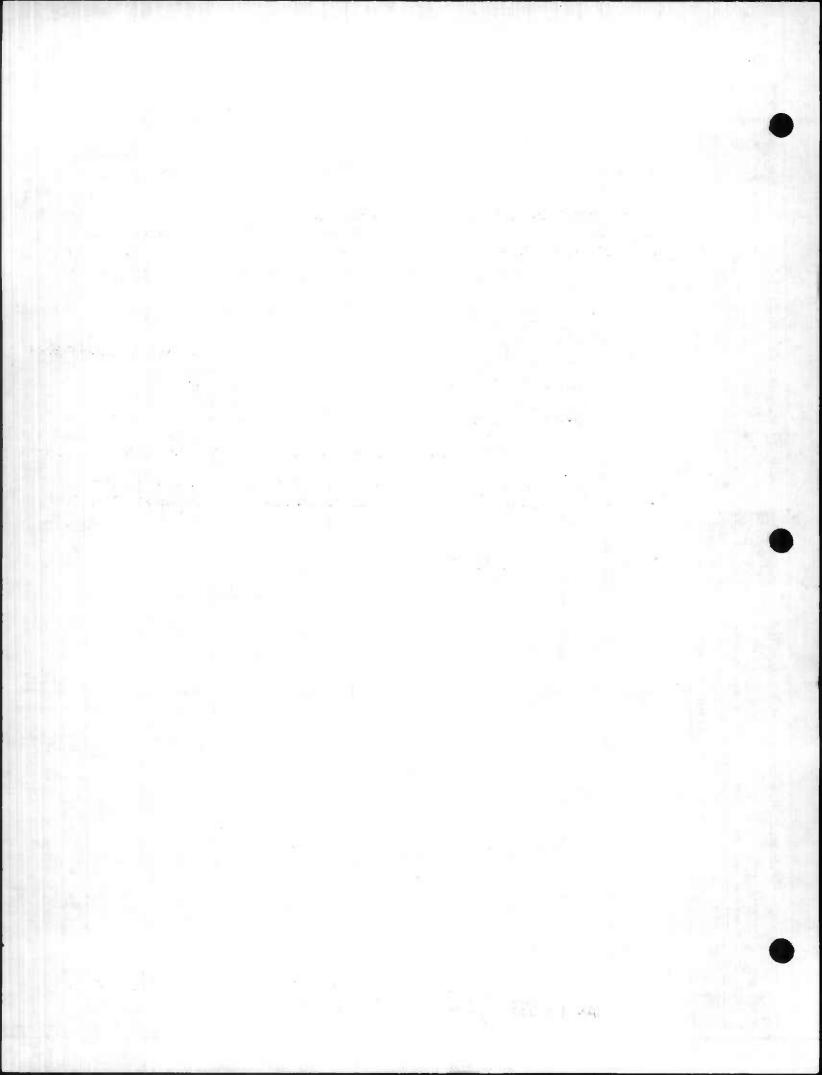
-1-1					C	GILIIIGa	te of L	Jealli		Reg. No.			
	1. Decedent'a No	ame (First, Midd							2. Date of D	Dev	Year	3. Time of Death	
/sician ledical	MAR	Υ Β.	AMRHEI	N					JAN	11	1 9999	4:20pm	
aminer	4a Facility Name	e (If not Institutio	n, give street and	f number)			4	b. City, Town, or	Location of Dea	th 4c. Co	unty of Death		
	IV		GERIAT			Kilad		MIDDLE If Under 24 Hrs	RIVER		BALTIM		
ral tor	5. Social Security 004-09	-5542	6. Sex 1 ☐ M 2 🔀		yrs. lest birtho	Months	er 1 Yeer Days	Hours Min.	8. Date of B Month, D March	26 19	9. Birthp Coun	place (State or Foreintry) Maine	
to	10a. State Md .	10b. County	İtimore	100	c. City, Town o	r Location	Esse	2X			1	0d. inside City Limi 1 ☐ Yes 2 1 N	
Funeral Director	10e. Street and I	Number eorge Av	/e.			10f. Z	ip Code	1		10g. Citizen of What Country? USA			
by	11. Maritel Statu		12. Wes I	Decedent Ever d Forces? les 2 1 No , Give or Dates:	in U,S.			spanic Origin? (S n, Mexican, Puer	pecify Yes or N to Rican, etc.)	No- 14. Race - American Indien, Black, White, etc. Specify: White			
To Be Completed		15. Deceder pecify only highe econdary (0-12)	nt's Education est grade complet Collec	ed) ge (1-4or 5+)							16b. Kind of Business/Industry  OWN home		
ပိ	17. Father's Nam	ne /First Middle	( act)		Homemaker								
Be	Deloi				18. Mother's Name (First, Mid Annie Leve						rraintey		
T			ship (Type, Print)		10h N	tailing Addre	ne /Strant	and Number or R			num State 7in	Code)	
i	John W		sinp (1900, 11mi)					ve. Balt				0000)	
thent of the signal of the sig	20e. Method of D			20	0b. Place of D cemetery,		~		Date	_	ion - City or To	wn, Stete	
		2 Cremation on 5 Other (5	3 Removal fr	rom State	Garden				15/99	Rossv	ille M	Md.	
		Funeral Service			4			s of Facility	10/33				
830d	Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md.21221  23a. Parl 1. Enter the disease, or complications that caused the death too not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate	
ysician Medical in	shock, or heart failure. List only one cause on each line.											Interval Between Onset end Death	
	Immediate Cause (Finat											2 6/60	
	disease or cond resulting in deat	ition (h)	θ	Due	to (or es a cor	needlience o	n. ^					. A.	
Je.		Apper an an Preum ania									3 which		
ami	Sequentially tist	conditions.	b	Due	to (or as a cor	nsequence of	i):						
M	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.												
g o O Int	cause. Enter U	That initiated events Due to for as a consequence of:											
	that infleted eve		resulting in death) Last										
Medical	that infleted eve		L.										
lan/Medical	that infleted eve		d						_				
/sician/Medical	resulting in deat	h) Last		to death but no	t resulting in th	ne underlying	cause giv	en in Part t.	23b. Die	d tobacco ua	e contribute to	o the cause of dear	
Physician/Medical	resulting in deat	h) Last		to death but no	t resulting In th	ne underlying	cause give	on in Part t.	23b. Die			o the cause of dear	
by Physician/	resulting in deat	h) Last		to death but no	t resulting in the	s e underlying	cause giv	en in Part t. 19 Imwww	23b. Did 10 24e. Wa		No 3 Pro	bebly 4 dinknown of the support of t	
by Physician/	resulting in deat	h) Last		to death but no	t resulting In the	Seme	cause giv	en in Part t. 19 Inwikir	24e. Wa	Yee 2 1 s en eutopsy formed?	No 3 Proi	ere autopsy finding ailable prior to mpletion of cause death?	
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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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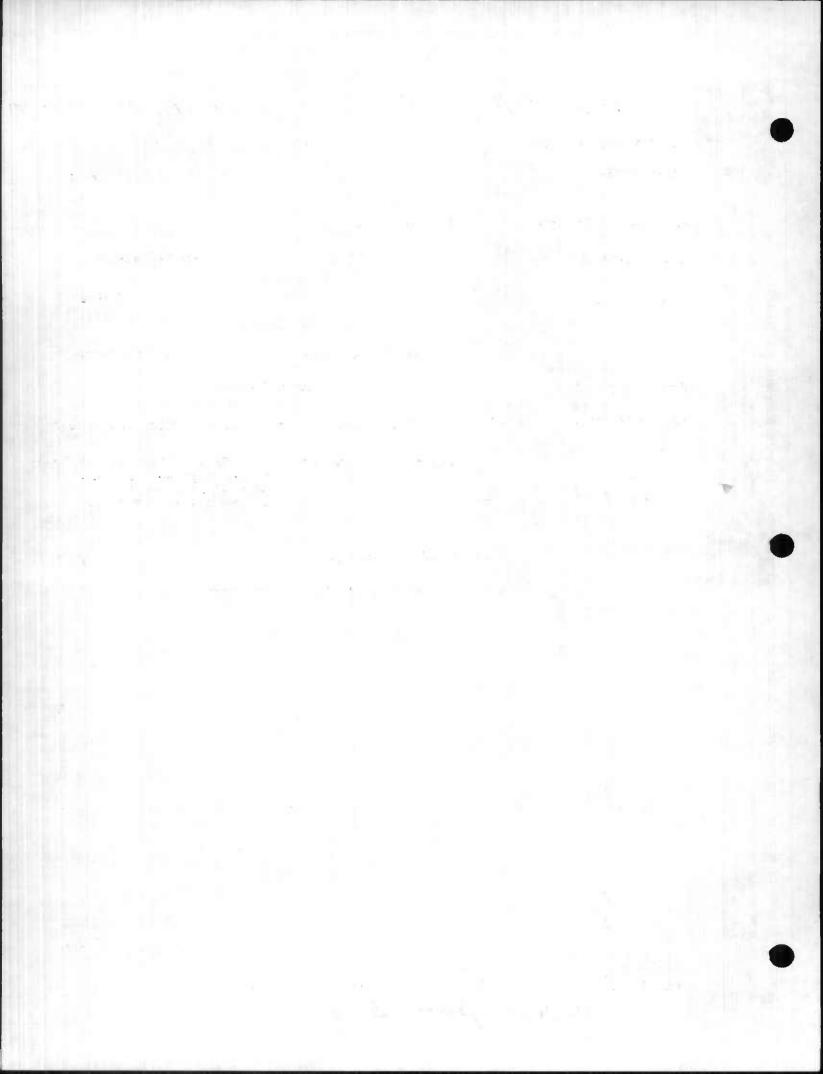
99 00680

		Certificate of Death Reg. No.														
2.0	hysician /Medical	Decedent's Neme (First, Middle, Last)     Amanda K. Arnold								2. Date of Death Month Dey Year January, 15, 1999 1430						
	zwedicai xaminer	4a Facility Name (If not institution, give street and number)  4b. City, Town, or							wn, or Lo			County o		1.10	J. Dallia	
60																
Fu	neral	5. Social Security Number	6. Sex 7.	7. Age (In yrs. last birtho			r 1 Year				irth	Birthplace (State or Foreig Country)			or Foreign	
	ector	219-02-7461	1□M 2⊠F	16	Months	Deys	Hours	Min.	July 3		82	Maryland				
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or theme 23a or 28a-1 ahow any injury or other traumatic avant, the Marical Exercises must be notified at		Usual Residence of Decedent														
	. E	10a, Stete 10b. County 10c. City, Town or Location										10d. Inside City Limits				
	0,	Maryland Anne	Arundel		Pasadena									1 ☐ Ye	s 2KI No	
	be notified Director	10a. Street and Number			, na.	10f. Zi	p Code				10g. Citiz	zen of Wi	nat Coun	lry?		
	1	855 Turf Val	21122						-1.0	U.S.	.S.A.					
	instrumt Instrumt Funeral	11. Marital Stetus	ent Ever in U,	S. 13. \	Wes Dece	dent of I	lispanic Ori	gin? (Spe	ecify Yes or N Rican, etc.)	10-	0- 14. Race - American Indian, Bleck, Whita, etc.					
	2	1 Never Married 2 Marri	Armed Force	1 ☐ Yes 2 ☑ No		1 ☐ Yes 2√ No									vhite	
	by y	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dete	os:	TE Tes ZE NO Specify.						4.1	Specify: White				
	completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of w							of work	16b. Kind of Business/Industry						
	al de	Elementery/Secondery (0-12)	or 5+)	life. DO NOT use retired)					TOTAL 9							
	1	11	N/A			Student					Nort	Wortheast High			hool	
	Be (	17. Father's Neme (First, Middle, I				18. A			18. Mother's Name (First, Middle,							
	To the	Richard D. Arnold Line								da K. Taylor						
	5	19a. Informent's Name/Reletionsh				-				ai Route Num						
	5.5	Richard D. Arno	ld Fat	Father			855 Turf Valley Driv			Pasade:	na,Ma	,Maryland 21122				
	8	20e. Method of Disposition		20b. P	lece of Dispo	sition (Ne	me of other pla	ark Jan.19		Date				or Town, Stata		
	- 6 - 6	1 Burial 2 Cremetion 4 Donetion 5 Other (Sp		Gle Gle	n Have	en Me	m.Pa	rk Ja	n.149	,1999	Glen	Bur	nie,	Mary]	land	
	- H	21. Signature of Funeral Service L	icensee /		22	. Neme e	nd Addre	ess of Facilit	у							
m 88	any ir	17/0:16	10: 11)							neral				1100		
		23a Part1. Enter the disease, or	mullications that caus	sed the death						Pasade:		ryıa	na z	1122 Approxim	ate	
		23a. Part1. Enter the disease, or shock, or heart failure. List of	one cause on each	h tine.										Interval B	etween	
Phys /Me	dical	Immediate Cause (Final disease or condition resulting In death)  Buproprion Intoxication  Due to (or as a consequence of):														
Exan																
	5															
ox 68760, certificate be executed iding physician and ise as the burial-transit	s the burishransit		b										i			
	Xar	Sequentially list conditions, if any, leeding to immediate		Due to (o	r es a conseq	uence of)	1:									
	burd B	cause. Enter Underlying Ceuse (Disease or Injury that initiated events	C										1			
587	the parties of	resulting in death) Last	.5-6	Due to (or	es e conseq	uence of):	:									
DIVISION of Vital Records, P.O. Box 6  To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending to completely lilled in by the luneral director, page 2 should be detached for use as	8 8	d.														
	Physician												1			
	ys l	Pert II. Other eignificant conditions confributing to death but not resulting in the underlying cause given in Pert I.								23b. Did tobacco use contribute to the cause of death?						
	de de									10	Yes 2	ANo	3 Prot	oably 4	Unknown	
	b db									24a. Wes an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause				y findings		
	to de													ir to		
	20 0									of death?						
	page 2 should										1 Yes 2 □ No 1 1 1 1 1 1 1				□ No	
	Be (	25. Wes case referred to medical examiner?														
	To dire	1 X Yes 2 No	Hospital: 1 1 Inpe	atient 2	ER/Outpatier	nt 3□ D	OA Ot	her: 4 Nu	rsing Ho	g Homa 5 ☐ Residence 6 ☐ Other (Specify)						
		27. Menner of Deeth  1 Neturel 5 Pending		28a. Dete of Injury (Month, Day Year)			28c. Inju Wo	ury at ork?		1 1	be how injury occurred			. 4.		
	atic	1 Neturel 5 Pending 2 Accident Investig			us hi now	8.6		Yes 34	LNo .	subject	ingest	ed m	eclica	EATUVL		
	THE PARTY	3 Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Pieca or							281. Location (Street end Number or Rural Route Number, City or Town, State)					imber,	
	ed in by the luner Certification:			Pos adena, 120 motorilas ar												
	cal cal	29e. Certifier  (Check only  (C														
	pletely lill edical	one) 25 Medical E	ui occurr	rred at the time, date and place, and due to the cause(s)					(3)							
	E SOU	29b. Signeture end title of certifier 29c. License number									29d. Date signed (Month, Day, Year)					
		Derun	I Chute in		O.C.M.F			C.M.F.			Janu	nuary 17 1999				
(	.\/	30. Name and address of person	no completed cause of	of deeth (Item	23a) (Type	Print)	-					-	-			
	Y	Dennis J Chafe 111 Penn Street, Baltimore, Maryland 21201												01		
	State	31. Dete filed (Month, Day, Year)	0 4000 32. Regi	state Signa	We .	4	1	10								
0	enietra <b>r</b>	JAN 1	9 1999	Parties	/	· ,	pago	us								



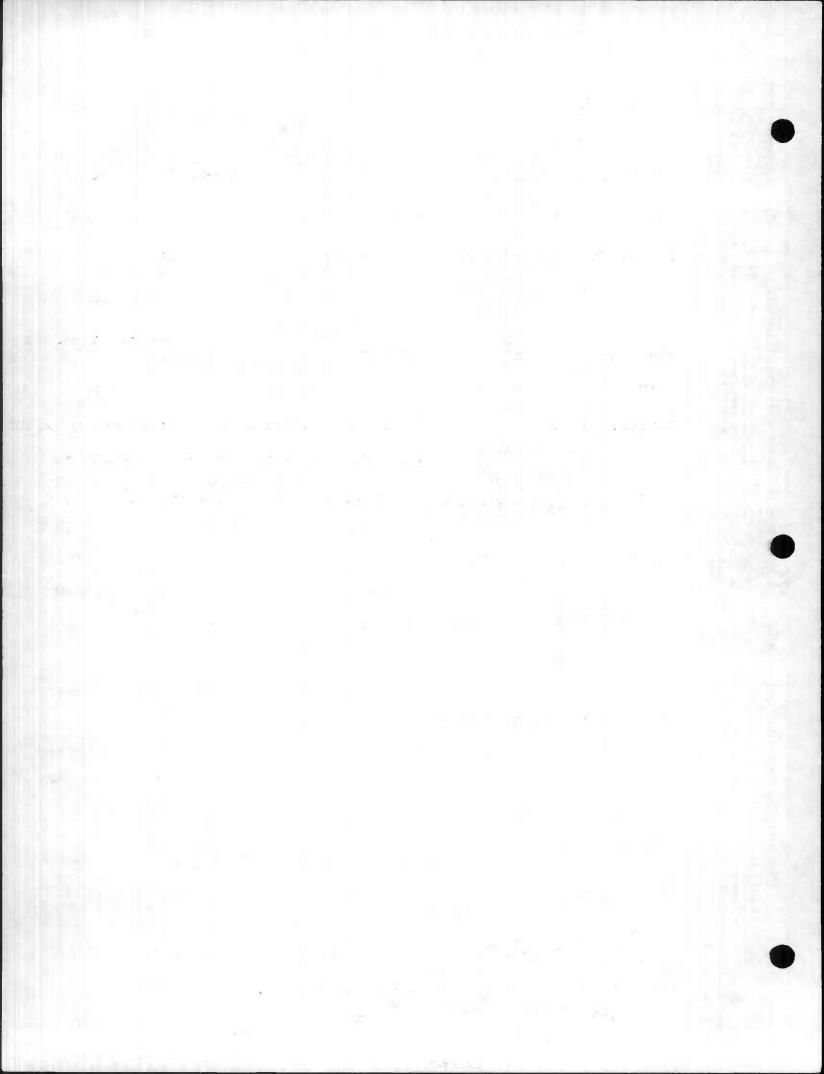
			Certificate	of Death	Re	g. No.	006	81
Physician	1. Decedent's Neme (First, Middle, Last)	0			2. Date of Death Month	Day	Year 3.1	ime of Death
nysician /Medical	HLMA HIS	130/1				14	99 11	1:45 pm
aminer	4a Facility Name (If not institution, give street and num	iber)		4b. City, Town, or L	ocation of Death	4c. County	of Deeth	
	Lorien Nursing Home		1 411-1-4	Columbia	T = -	Howar		
rai	1□M 2K7 E	7. Age (In yrs. lest birti		Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Dey,			Stete or Foreign
or	Usual Residence of Decedent	84	10.		Dec. 16	, 1914	Marylar	nd
	10a. Stete 10b. County	10c. City, Town	or Location				10d. In	side City Limits
ò	Maryland Baltimore	Ellico	tt City				1[	☐Yes 2∏No
Director	10e. Street and Number	LITTEO	10f. Zip C	ode	10	g. Citizen of W	/hat Country?	
	10113 Frederick Road		2104	2	Ur	nited S	tates	
Funeral		dent Ever in U,S.	13. Was Deceder	at of Hispanic Origin? (Sp. Cuban, Mexican, Puerto	ecify Yes or No-	14. Race	- American Inc	lien,
ò	1 Never Married 2 Married 1 Tyes If Yes, Giv. 3 ₩ Widowed 4 Divorced Yeer or Da	No.	1 □ Yes 25		ornoun, etc.,		White	
ted	15. Decedent's Education	16a.	Decedent's Usuel (	Occupation	king 1	6b. Kind of Bu	siness/Industry	
Completed	(Specify only highest grade completed)  Elementery/Secondary (0-12)  College (1-	4or 5+)	life. DO NOT use	done during most of work retired)	uniy .			
Con	2 0	wa	rehouse v				arehous	e
Be	17. Fether's Neme (First, Middle, Last)				ne (First, Middle, M	leiden Sumem	θ)	
2	John Emory Bell			Anna Kai	ufman			
	19e. Informent's Neme/Reletionship (Type, Print)		Mailing Address (S	Street end Number or Ru	ral Route Number,	City or Town,	Stete, Zip Code	)
	Marcia Buchwald - daughte	10		erick Road,				
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from S	cometen	Disposition (Neme v, cremetory or other	er plece)	Dete 2	Oc. Location -	City or Town, S	tete
	4 Donation 5 □ Other (Specify)		Park Cer	netery	1/18/99 H	Baltimo	re, Mar	yland
once.	21. Signature of Funeral Service Licansee		22. Name end	Address of Facility Lot	udon Park 20 Wilker	Funer	al Home	
·	unny. gink			Ba	ltimore,	Maryla	nd 212	
	23a. Pert1. Enter the disee e, o contributions that ca shock, or heart failure. Let only one ceuse on ea	used the deeth. Do n ich line.	ot enter the mode	of dylng, such es cardiec	or respiretory arre	st,	Inter	oximate vel Between
an	In a state Course (First						Onse	et and Deeth
cal ner	Immediate Cause (Fine) disease or condition resulting in death) a.	rebral :	Huppen	,e			· y	m
	1.	Due to (or es e c	-	,				
ai Examine	b	rend W	My our	deven de	une		ye	an
Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	Due to (or es a c	onsequence of):					
	cause. Enter Underlying Ceuse (Disease or injury that Intrieted events						1	
edicai	resulting in deeth) Last	Due to (or as e co	onsequence of):				1	
n/Med	d							
Cia	Pert fl. Other significant conditions contributing to de	ath but not resulting in	the underlying cau	se diven in Part f	23h Did tol	Dacco use cor	tribute to the	suss of death?
hys	Strain Significant Solidations Contributing to de-	sat not resulting in	underlying odd	oo giron ii i dit i.		s 2 No	3 Probably	
by Physic								A
Completed by Physician/					24a. Wes er		24b. Were au available	topsy findings
piet					pendin		complete of deeth	on of cause
Comp					1□ Ye	s 2 No	1 🗆 Yes	200 No
To Be C	25. Wes case referred to medical			26. Plece of Dee	th (Check only one	41		
	examiner?	patient 2 ER/Out	patient 3 DOA	Other \	ome 5 Reside		er (Specify)	
	27. Manner of Deeth 28a. Date of (Month	f Injury 28b. T	ime of 280	Injury at Work?	28d. Describe ho	w injury occurr	ed	
ation	Accident Investigation		M	1 Yes 2 No				
tific	3 Suicide 6 Could not be determined 28e. Placa buildin	of Injury - At home, fer g, etc. (Specify)	m, street, factory, o	office	28f. Location (Str. City or Town	eet and Numb Stete)	er or Rural Rou	te Number,
Completely filled in by the funeral Medical Certification:	- January Control of the Control of	g. c.c. ( <i>speed.</i> )/				-		
edical	29e. Certifier (Check only Medical Examiner: On the ba	sis of examinetion and	death occurred et	the time, date end plece my opinion, death occu	and due to the ca	use(s) end ma ite end plece, i	nner as stated. and due to the o	ause(s)
Med	one) and menn	er steted.						
_	29b. Signature and the of certifier	~	290. [	icense number	28	Lete signed	i (Month, Dey,	1001)
	As Und and	m ")		104345	J	Iznuar	1 13:19	199
	30. Name and address of person who completed cause							
			h Drive,	Columbia, N	D 21045			
State	31. Dete filed (Month, Dey, Year) 32. Re	gistrer's Signature	4	1				
policirar	1410 1 9 1999	A. Arrigian	1-1	40- 1/1				

DHMH 16 Rev 6/95



	1. Decedent's Nen	me (First, Middle, La	st)			tificate of		2. Dete of D	Reg. No. eath Dey	Year	3. Tima of Deeth
Physician /Medical		by Byron, Sr						January	12, 19	99	2:45 AM
Examiner	4a Facility Neme	(If not institution, giv ndon Way	a s <i>treet</i> en <i>d n</i> un	nber)			4b. City, Town, or Luthervi			imore	Co.
neral ector	5. Social Security 220–03–080	02	Sex X M 2□F	7. Age (In yrs. 82	last birthday) Yrs.	If Undar 1 Yaa Months Dey		8. Dete of B (Month, D June 02	irth 9, 1916	9. Birthpl Count Baltim	laca (Stata or Foreign try) One, Marylar
5 til	Usual Residence of 10e. State	of Decedent 10b. County		10c. Cit	y, Town or Lo	cation				10	Od. Inside City Limits
Examinet must be notified at by Funeral Director	Maryland	Baltimore	Co.	Lu	thervill	_					1 ☐ Yas 2X No
Funeral Director	10e. Street and No. 204 Strath					10f. Zip Code 210	93		10g. Citizen of V United Sta	ates o	f America
by Fune		rried 2⊠ Married 4 □ Divorced	Armed Fo	2 No	I I	I□Yes 2□XN		-100	Bied	e-America k, White, e	etc.
Completed	(Spe	15. Decadent's E ecify only highest gre	da completed)		16e. Deced (Give	lent's Usuel Occ kind of work don OC NOT use reti	upation a during most of wor ed)	rking	16b. Kind of Bu		
Omp	Elementery/Sec 12	condery (0-12)	College (1	-4or 5+)		rincipal		Engineering/ State of Maryland			
To Be	Frank Jay						Lottie Bl	anche Ki	9		
		Name/Reletionship ( ona(nee Hugh		(Wife)	202	ng Address <i>(Stre</i> rathdon Wi	et end Number or Au By Lutherv	ural Route Num Ville, Mai		Stete, Zip 1093	Code)
- no 10	4 Donetion	Cremation 3 5 Other (Special	<b>y</b> )	Stata Dn	Place of Dispo	sition (Name of netory or other p e Cemeter	(eca)	Data 01/20/99	Baltimore		
bepartment of Health and Mental Hygena. Important: if item 27 is marked other than "natural part of properties of the partment	21. Signafure of Funeral Service Licensee deffrey L. Gair  22. Nama and Addrass of Fecility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md.										
	23a. Peri 1. Enter tha disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only die ceuse on each line.  Immediate Ceuse (Finel disease or condition resulting in death)  Due to (or as a consequence of):										Approximete Interval Between Onsat and Death
alner -	Due to (or es e consequence of):  b. HYPERTENSION										20 YRS
edicai Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury										
n/Medical	Cause (Disease or injury that Initiated events resulting in death) Last  Due to (or es e consequenca of):  d.										
Physician/Me	Pert II. Other sign	ificant conditions of	ontributing to de	ibuting to death but not resulting In the underlying cause given in Pert I.					d tobacco use co	ntribute to	the cause of death
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, page 2 should be detached for use as Completed by Physician/Me								24e. Wes en eutop: performed?			ere eutopsy findings alleble prior to mpletion of causa death?
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ral director, page 2 s : To Be Compli	25. Wes case refe exeminer? 1 Yes 2	,	Hospitel:		FD/0 4-4		26. Plece of Dec	1.4		(Cih	
= F	27. Menner of Dee	No oth 5 ☐ Pending investigetio	28e. Dete d (Mont		28b. Time of Injury	28c. In	4 Li Nursing F	-	sidenca 6 Oth how injury occur		y)
led in by the funera Certification:	3 Suicide 4 Homicide  Could not be determined  28e. Placa of Injury - At homa, ferm, streat, factory, office building, etc. (Specify)  28f. Location (Street end Number or City or Town, Stete)									er or Rure	I Route Number,
completely filled in by the fune Medical Certification	29a. Certifier (Check only one)	1 Certifying Pt	niner: On the be	best of my kno asis of examine her stated.	wledge, deeth tion end/or Inv	occurred et the restigetion, in my	time, dete end plece opinion, deeth occu	e, end due fo th urred et the time	e ceuse(s) end me e, dete end pleca,	enner es st end due to	tated. the cause(s)
W W	29b. Signeture en	d fifte of cartifiar	_	N.D.		29c. Lica	501		29d. Date signe	d (Month,	
1	30. Name and edd	dress of person who					UD 217	04	7/2		
	7505 OSLER DRIVE TOWSON MD 21204										
State	ate 31. Deterried (Month, Dey, Year) 32. Registrer's Signeture										

	1. Decedent's Na	me (First, Middle, Las	t)		5071	tificate of		2. Dete of De		V.=	3. Time of Deat	
ician dical	Dav	rid Brown						January Tanuary	Day 14 th	Yeer 1999	0349	
niner		(If not institution, give		1.6	4		b. City, Town, or L		h 4c. Count	y of Death		
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or	248-42 Usuel Residence			0 2				06-0	8-06	S	C	
	10a. State	10b. County		10c. City, T	own or Loc	ation					10d. inside City Lin	
ctor	MD	NA		Bal	timor	ce				x X Yes 2[		
Oire	10e. Street and N					10f. Zip Code			10g. Citizen of	g. Citizen of What Country?		
Funeral Director	533 N.	Washing				21205			USA			
une	11. Marital Status		12. Was Decedent Armed Forces?		13. W	as Decedant of F Yes, specify Cub	lispanic Origin? (Sp en, Mexican, Puerto	ecify Yes or No Rican, etc.)	)- 14. Ra Ble	ce - Ameri ck, White,	can Indian, etc.	
by F		rried 2 Merried 4 □ Divorced	1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Datas:	NO	1	□ Yes a∏No	Specity:		Speci	b: B1	ack	
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	\$☐ Buriel 2	2 Cramation 3										
To Be Completed by Funeral Director			17	VOS	_		C = 20h -					
- SUC	20b. Method of Disposition  **D Buriel 2 Cramation 3 Removal from Stete 4 Donetion 5 Other (Specify)  20b. Plece of Disposition (Neme of cemetary, cremetory or other pleca)  Voshell Mem. Gardens 01-19-99 Dunce  22. Name end Address of Fecility  WM. C. March FH 1101 E. North A											
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Completed by Physiclan/M	05 Was agas sale	resed to madical		nt 2 🗆 E E	VOutpatient	3□ DOA Ott	28. Place of Dee		one) Idence 6 □Ot	ther /Snec	ih.)	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Dey Yeer Month **Physician** Catherine Anna Bell 10:25 p.m. 11 1999 January /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) July 25,1919 Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys Months 1□M 2□F Hours 212-14-9921 79 Maryland Director Usuel Residence of Decedent the Meryland 10e. Stete 10c. City. Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23s or 28s-f show traumstic avent, the Medical Examiner must be notified at 1√ Yes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6144 Parkway Drive U.S.A. 21212 Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2∑ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indien. 11. Maritel Status Bleck, White, etc. 72 hours efter 1 Never Merrled 2 Married 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within it end Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home yrs. 17 Fether's Name (First Middle 1 ast) 18 Mothar's Nema (First Middle Meiden Sumeme) Ida Button Thomas G. Baker Marie 19b. Malling Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Pages 1 and 7 of Heelth Mr. Thomas Bell/Husband Baltimore, Md. 21212 6144 Parkway Drive other 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Mathod of Disposition 20c. Locetion - City or Town, Stete Department of important: If it any injury or o 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 111top Service Corp. 1/14/99 Towson, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Poneral Service Licensee 22. Neme end Address of Fecility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23e. Part1. Enter the disees of conshock, or heart failure. hat caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximata Intervel Batween Onset end Deeth **Physician** Immediata Causa (Final disease or condition resulting in deeth) /Medical Lymphoma Examiner Due to (or as e consequanca of): Examiner certificate be executed the ettending physician end hed for use as the buriel-transit Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disaasa or Injury Due to (or es e consequence of) Box 68760 Physician/Medical thet initieted events resulting In death) Lest Due to (or as e consequence of): P.O. Part II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the ceuse of deeth? that the signed by ti 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records. þ requires 24b. Ware autopsy findings eveileble prior to complation of cause of daath? 24e. Was en eutopsy performed? Completed peen We pege 2 s hes The 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was cese referred to medicel exeminer? 26. Piece of Deeth (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residance 6 Other (Specify) <sup>o</sup>L 1 ☐ Yes 2 XNo After this funeral 27. Mannar of Death 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Natural 5 Pending I Director: A 1 TYes 2 TNo deeth. Investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, factory, office building, etc. (Spacify) filled in by 4 Homicida efter within 24 hours To the Funerel ( 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) and menner es steted.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier. 29c. License number 30. Nema end eddrass of person who complated causa of daath (Itam 23a) (Type, Print) Baltimore, M.O. Boulevard 60

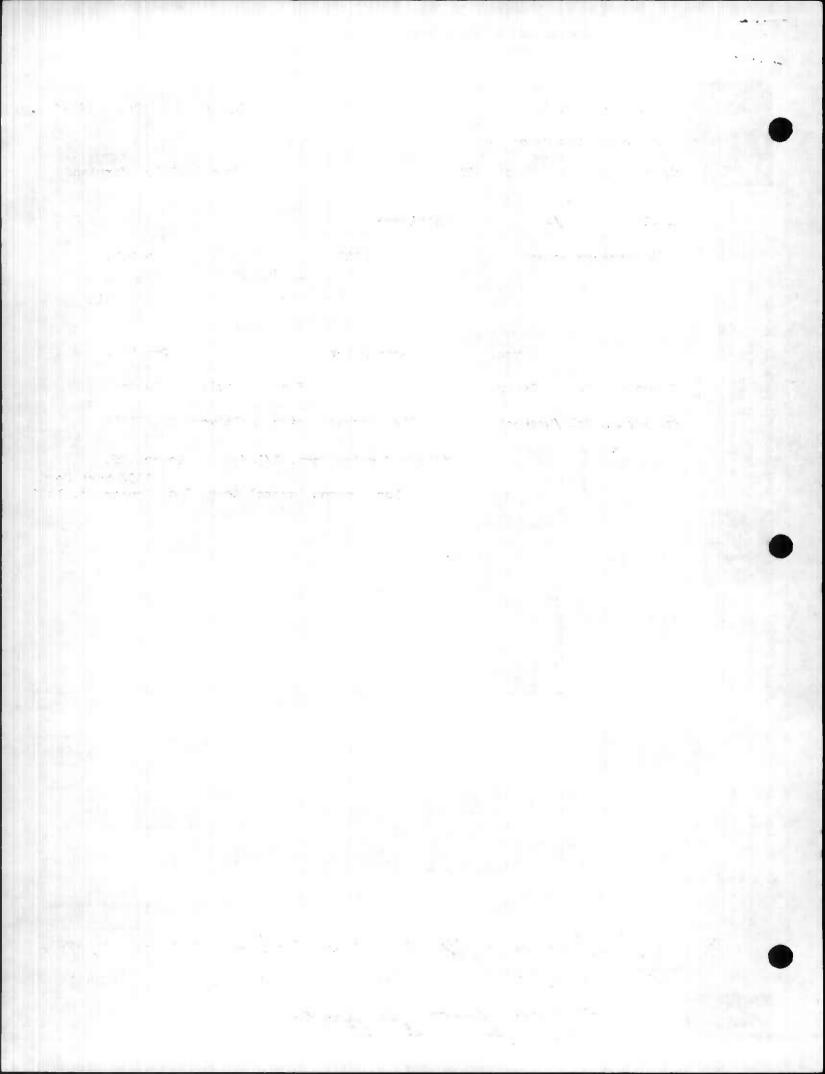
31. Date filed (Month, Day, Year)

JAN 19

State

Registrar

32. Registrer's Sig



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEM: #5 PER F.H. G768 2-26,1999 WR. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** MEDRGE L. BIRCHTT 4:25 Am JANUARY 10 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner MSU) DRIEN NURSING HOME COLUMBIA HOWARD MA If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Yeer 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Months t M 2□ F Deys 51 Yrs Director March 21, 1947 ÍN Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or thems 23s or 28s-f shor traumatic event, the Magical Examinat, must be notified at YS Yes 2 No Columbia MD Director Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5381 Brookway, Apt.-4 21044 United States Funeral 12. Wea Decedent Ever in U,S Armed Forces? Unk. Was Decedent of Hispanic Orlgin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 11. Marital Status Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 8 1 Yes XX No Specify: White þ 3 ☐ Widowed ★ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementery/Secondary (0-12) College (1-4or 5+) US Army Finance Center Computer Operator 12 17. Fether's Name (First, Middle, Last) 18. Mother'a Neme (First, Middle, Meiden Sumeme) Martha Brouhard George L. Birch, Jr. 19e. Informent'a Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) George L. Birch, Jr. / Father 860 S. Meridan Road Greenfield IN 46140 other t 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Semovel from State Injury or January 13, 1999 Park Cemetery TN 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Victor P. Dola, Jr. 22. Neme end Address of Fecility any Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 23e. Pert1. Enter the disease, or complications that are an idea deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on an arrest, Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Final disease or condition resulting In deeth) Examiner Examiner OBSTRULTION physician and s the burial-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): XTENSIVE METASTATIC COLON CANCER + MONTH Physician/Medical 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown FUNGEMIA 2 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed ANEMIA CARLINOMA TOSE, 1 Yes GASTROINTESTINAL OBSTRUCTION DUE TO 26. Place of Deeth (Check only one) 25. Wes case referred to medical exeminer? Be Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 10 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Certification: Netural 5 Pending 1 Yes 2 No Investigation 2 Accident 8 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

Scartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner es stated.

10802

MD

MD

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

SHAUKAT

32 Registrer's

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end manner steted.

29c. License number

HICKORY

29d. Date signed (Month, Day, Year)

RIDGE

Box 68760 P.O. Division of Vital Records, I or Attending Petter death. 24 hours e To the within 2

Maryland 21215-0020

Baltimore,

Registrar

Medical

29e. Certifier

(Check only one)

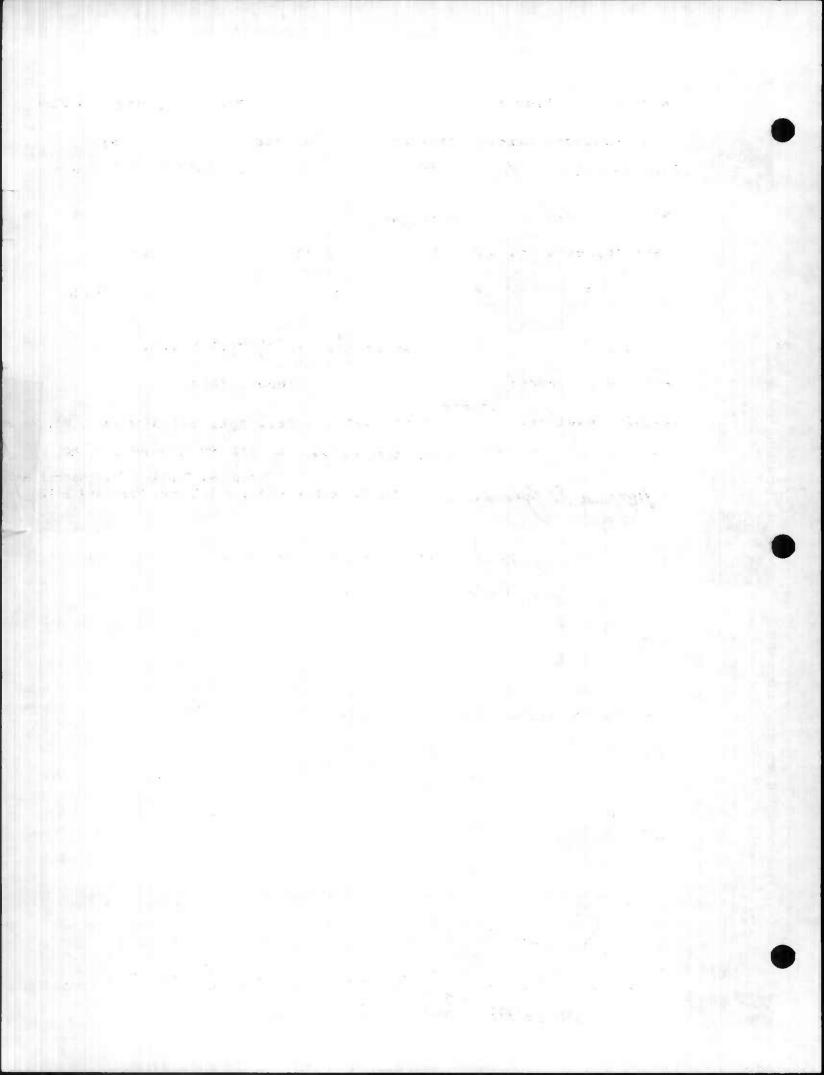
29b. Signature and title of certifier

AMOONIA

PARTIE OF THE PROPERTY. THOUSAND THE State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lois Elaine Blount 1:22pm January 18, 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Apt. T-1 1401 Anglesea Street Baltimore 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7 (Month Day Year) 7 (Month Day Year) 7 (13 -1 3 -1 9 3 9 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 2XF 218-36-0933 USA Director Usual Residence of Decedent the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23s or 28s-1 show treumstic event, ms Medical Examiner must be notified at MD n/a 1X Yes 2 No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1401 Anglesea St. Apt T-1 21224 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Pages 1 and 2 should be filed within 72 hours effer of nent of Heelth and Mental Hygiene.
Int: If Hem 27 is marked other than "natural", or itea ary or other treumetic event, in Med call Examinating 1 Never Married 2 Married 1 ☐ Yes 2 K No If Yes, Give White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Receptionist/Purchasing G.A.F. Elementary/Secondary (0-12) College (1-4or 5+) 12th 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be William Snyder Irene Talbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) spouse Daniel Blount Jr. 1401 Anglesea St., Apt. T-1 Baltimore, Md. 21224 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1/21/99 Crownsville , MD permit. Page Department of Important: If eny Injury or page. Crownsville VA Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Joseph N. Zannino Jr. Funeral Hm. 21. Signature of Funerei Service Licensee 263 S. Conkling St., Baltimore, Maryland 21224 annes 23a. Part1. Inter the disease, or comparations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) AD Eno CALCIDON 6 Month Examiner Due to (or as a consequence of): Physician/Medical Examiner In Enocarcia cua physicien end the burial-transit death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) as USB I signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 No 3 Probably 4 Unknown VAJCular Diffor ARTERIO Scheloti à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed HypznRusta is certificate has director, page 2 s 1 Yes 2000 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P After this funeral 28a. Date of Injury (Month, Dey Yeer) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: 5 Pending investigation in 24 hours etter the Funeral Director: Aft 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Hospital edicai 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA/40. Imok 31. Date filed (Month, Dey, Year) 32. Registrart State JAN 1 9 1999 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent' eme (First, Middle, Last) 2. Date of Death Month **Physician** UTH ANN BROOKS 1999 5:00 AM JAN /Medical 4a. Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** ATOPS VILLE If Under 24 Hrs. 8. Date of Birt (Month, Da NURSING BAUTIMORE CO 1.06 HOME 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Yeer 6. Sex 9. Birthplece (State or Foreign **Funeral** 397-18-3036 Usual Residence of Decedent 1□ M 2 F Months Deys Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Yes 2 No Director 28a-f 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? b 3314 BLUD U.S.A Items 23a Funerai 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U.S. 1 Never Married 2 Married "natural", or Specify: þ 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NURSING espartment of Health and Mental Hygs Important: If Item 27 is marked other timy Injury or other transmissed other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be LIFFORD DIETERLE RUTH BORZ ARMINGEL 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) S.VITE SIO BALTO. 1MD. 21202 ARTHUR DRAGERS 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial Cremation 3 Removal from State 4 Donation 5 Other (Specify) CREMATORY BALTO CO- MD 21. Signeture of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Final Meumonia 2 weeks disease or condition resulting in death) **Examiner** Due to (or es e consequenca of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 HUnknown decubitus ulcers p 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24e. Wes an autopsy performed? Parkinson's disease Delydratin 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 40 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 1 Divatural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

physicien and s the burial-transit that the death certificate be executed P.O. Box 68760, Records, certificete Division of Vital To the Hospital or Attanding Physician: within 24 hours efter death.

To the Funeral Director: After this certifice completely filled in by the funeral director, to edicai

altimore, Maryland 21215-0020

29b. Signature and title of certifier

29c. License number D52544

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29d. Date signed (Month, Dey. Year)

11,1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Rd #4 Benjamin 21228 S. Lee, M.D., 500 N. Rolling Catousville MD

31. Date filed (Month, Dey, Year) State Registrar 9 1999

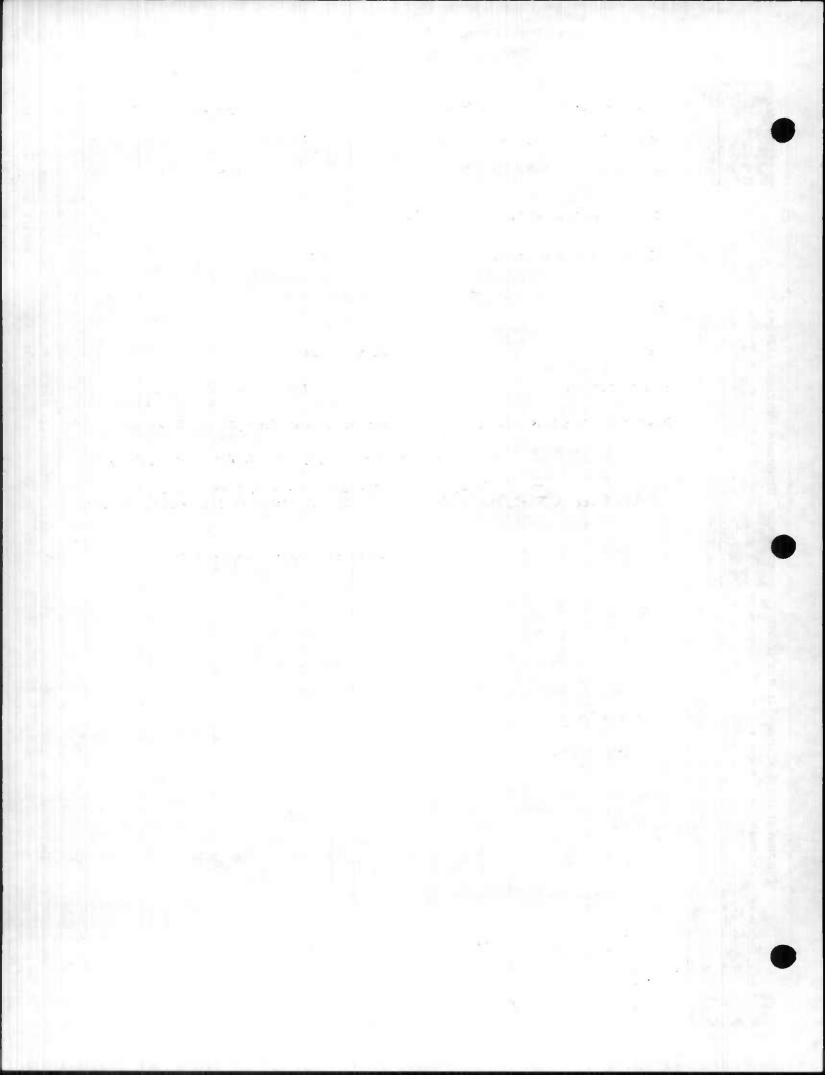
29a. Certifier (Check only one)

32. Registrer's Signature

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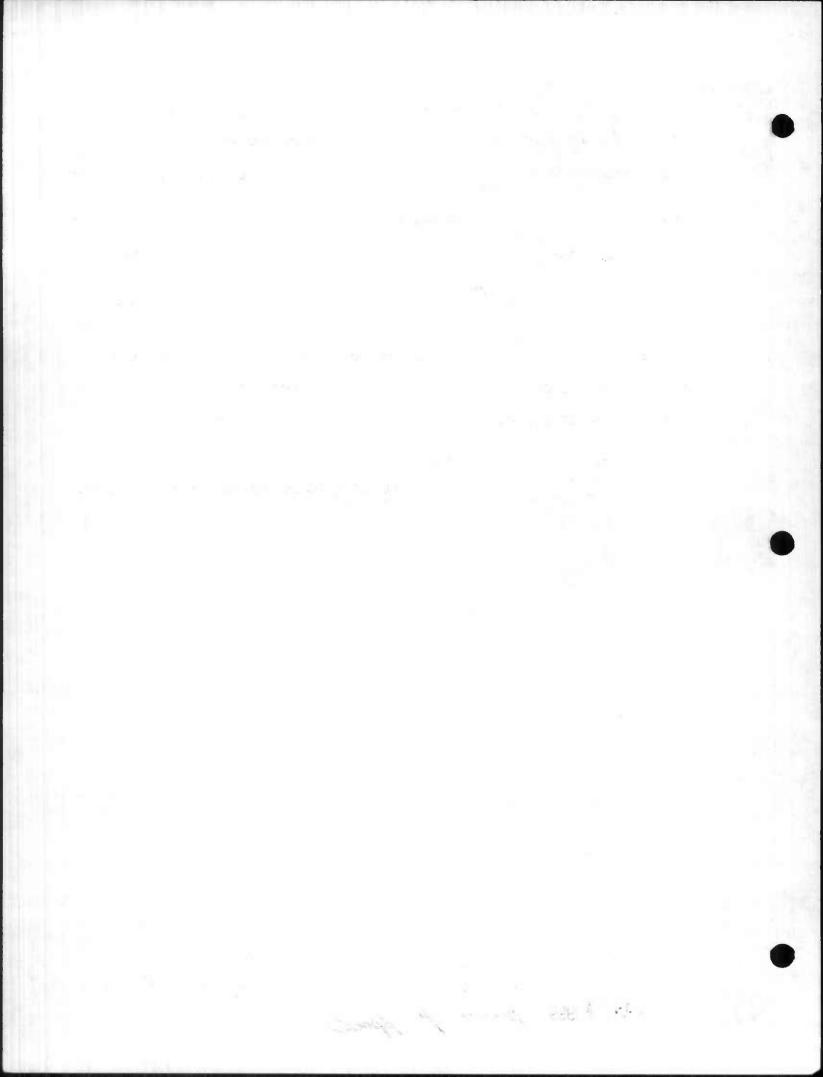
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DHMH 16 Rev 6/95



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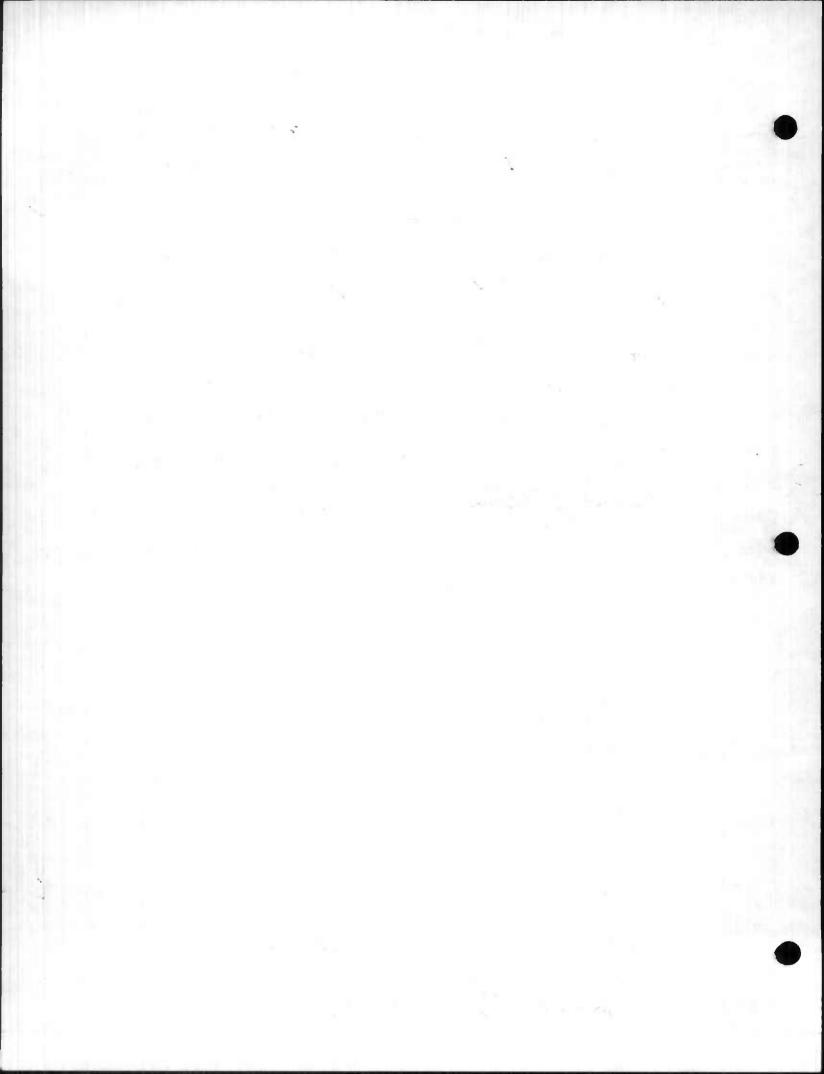
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** MARY BATTAGLIA Month 9:45 PM /Medical 4b. City, Town, or Location of Deeth 315, Ingleside Au 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner NURSING HOME FUREST HAUEN BALTIMORE if Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth 0972471911 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Months Deys Hours 87 Yrs. 212-12-6665 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21228 USA 2134 Chantilla Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No if Yes, Give Yeer or Detes: 11. Merital Status Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0020 "natural", or Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within nent of Health and Mantal Hygiene. Int: If Itam 27 Ia marked other than ' Iry or other traumatic event, Ina Ma Elementery/Secondery (0-12) College (1-4or 5+) Factory Machine Operator 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Adelina Garbo Vincent Lamartina 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Adelina Parsons/Daughter 2134 Chantilla Rd. Catonsville, Maryland 21228 20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete permit. Pege Department of Important: If it any injury or 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) New Cathedral Cemetery 1/18/99 Baltimore e of Funeral Solice Licensee 22. Neme end Address of Fecility David J. Weber Funeral Homes, P.A. 5311 Edmondson Ave. Baltimore, MD 21229 23a. Pert1. Enter the disease, promplications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Acuti Myvondial Ischemia
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1 Yes 2 No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending Investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dit completely filled in 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.
2 Medicel Examiner: On the bests of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) end menner stated. Medical 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Jan 14, 1999 27541 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GETHA RAJA 4367 HULLING FORRY RD BALT, MD 2122 31. Dete filed (Month, Dey, Year)

JAN 19199 32. Reg krer's Signeture State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 1 1 6 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death RELCHER GEORGE 1999 11:05PM JANUARY 12 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth GOOD SHMARITAN HOSPITAL BALTIMORE CITY BALTIMORE, MD if Under 24 Hrs. Hours Min. If Under 1 Year Months Deys 5. Social Security Number 6. Sex. 1 M 2 F 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 227033509 84 Yrs. June 20,1914 West Virginia Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. fnslde City Limits Virginia Campbell Lynchburg 1X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 113 Langhorn Lane 24504 United States 12. Wes Decedenf Ever in U.S. Armed Forces? 14. Rece - American Indien, Bleck, White, etc. 11. Merital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) ☐ Yes 200No Yes, Give 1 Never Married 2 Married 1 ☐ Yes ②ONo Specify: White Specify 3 Widowed 4 □ Divorced Yeer or Detes 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Salesman Insurance 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surname) James Belcher Ida Galford 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Allen L. Belcher / Son 508 Sussex Rd., Towson, MD 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from Stete Green Mount Crematory 1/15/99 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD D dolla 21286 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Immediate Cause (Finel disease or condition resulting in deeth) PNEUMONIA 06 DAY Due to (or as e consequence of): MROSPPSU 06 DAY Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Due to (or es a consequence of): Part ft. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DISSEMINATED INTRAVAJOULAR CUTAGULATION 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was en autopsy performed 1 ☐ Yes 2 No 1 Yes 2 No 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 1 Naturel 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 8 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the ceuse(s) end menner stated. 29a. Certifier

Examiner Box 68760. certificate be P.O. Records. Division of Vital he Hospital or Attending Ph n 24 hours after death. he Funeral Director: After th within 2

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Certification:

Medical

(Check only one)

29b. Signature end title of certifier

**Funeral** 

Director

show

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filed within 72 hours after Hygiane.

12 should be filed w h and Mental Hygier 7 is marked other th

permit. Pages 1 and 2 sh Department of Haaith and Important: if Item 27 is m any injury or other traum

Physician /Medical

attending physician and for use as the bunal-transit

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Baltimore, Maryland 21215-0020

the Maryland

State Registrar

31. Dete filed (Month, Day, Year) JAN 1 9 1999

AJAY CHAWLA, MO 32. Registrer's Signeture

AJAY CHAWLA MD

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

GOOD SAMPRITAN HOSPITAL, BALTIMORES MD 21299

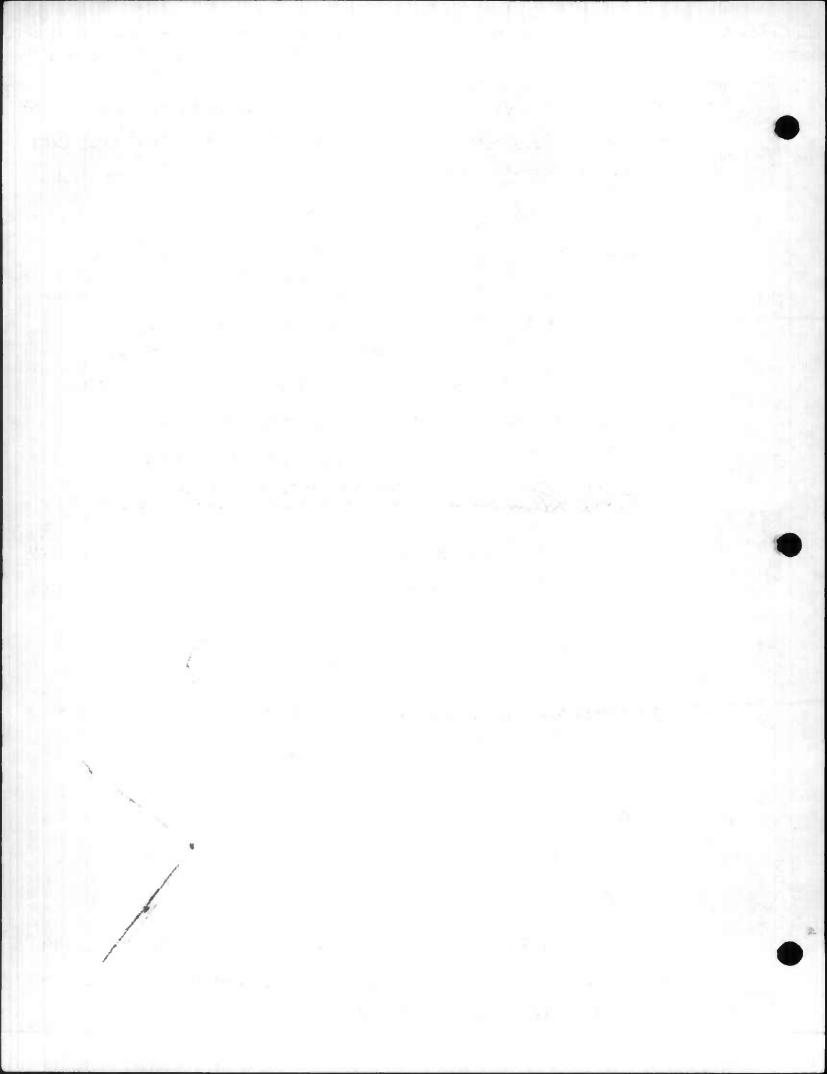
29c. License number

P-12556

29d. Dete signed (Month, Day, Year)

JANUARY 12, 1999

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene 9 9 0 6 9 2

						(	Certifica	te of	Death		Be	g. No.	U	0002	
	L-R-U		1. Decedent's Name (First, Middle, La	st)		J-701	2761		Miles (a)	2	2. Date of Deat	h		3. Time of Death	h
	Physici /Medi		SARA						BUDD		J A N U A R	Y 13	1 9 9 9	11:15	AM
	Examir		4a. Facility Name (If not institution, giv	e street and numb	er)				4b. City, Tow	vn, or Loca	ation of Death	4c. County	of Death		
			SHORE NURSING	& REHAB	ILITA	TIO	N CTR		DE	NTON		CAR	OLIN	E	
1	Funeral		5. Sociel Security Number 6. S		Age (In yrs. I	ast birtho		r 1 Year	If Under 2	24 Hrs. 8	B. Date of Birth (Month, Day,	Vanel	9. Birthpl	lece (State or Fore	eign
	Director		579-48-3461 1 M 2CXF 89 Yrs. Months Days								ug. 18			nington,	
	pui *		Usual Residence of Decedent  10a. State 10b. County		10c City	Town	or Location	13							
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	the Maryla 28a-f sho	Director	Maryland Talbot		Ox	ford									140
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		un.	11. Marital Status	12. Was Decede	es?	5.	If Yes, sp	ecify Cub	an, Mexican,	Puerto R	ify Yes or No- ican, etc.)		ce - America ck, White, e		
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	Physician		23a. Part1. Employ disease, or com shock, or mart feilure. List only	one cause on eac	h line.							Interval Between Onset and Death			
	/Medical	3	Immediate Cause (Final disease or condition resulting In death)  a. Consistive heart failure  Due to (or as a consequence of):												
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	death e etter	Physician/	Part II. Other significant conditions of	ontributing to deat	not resu	Itina In th	ne underlying	cause oi	en in Part I.		23b. Did to	bacco use co	ntribute to	the causa of dea	th?
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ion	Attending Firdeeth.	atio	1/⊒Natural 5 ☐ Pending 2 ☐ Accident investigation		Dey Year)	Inju	M M		Yes 2□N	No					0
Division	or Attendi efter deeth. Director: A d in by the f	2	3 ☐ Suicide 6 ☐ Could not be determined	289. Placa of	Injury - At hor	me, farm	, street, fecto	ry, office		28			per or Rura	Route Number,	
Ö	s efter s efter il Direct	Certification:	4 - Hounida	building,	etc. (Specify	,				trail.	City or Town	, 31818)			
	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in		29a. Certifier 1 Oertifying Ph	yalclan: To the be	st ot my knov	vledge, d	eath occurred	at the ti	me, date and	f place, an	d due to the ce	use(s) end me	enner es st	eted.	
	To the Ho within 24 To the Fu	edica	(Check only 2 Medical Exam	and manner	steted.	on end/o	or investigation	n, in my c	pinlon, death	h occurred	at the time, da	ate and place,	and due to	the ceuse(s)	120
	To the Hospital within 24 hours of To the Funeral Completely filled	2	296. Signature and title of Certifier	0/	110		29	c. Licens	e number	311	29	d. Date signe	d (Mongh )	Day, Year)	
			1/11	Tall	-	19	0	00	do	54		1/1:	3/7	9	
			30. Name and address of person who	completed cause of	deeth (Item	23a) (Ty	pe, Print)	-	. /		4 ~	- /	1	- 0 - 11	,
	9		ANDUBA	FUEN	mo	9	16	·U	rash	ingi	in st	Ca	pron.	m) 2160	2/
	Sta	te	31. Dete filed (Month, Dey, Year)	Q 1000 N	strar Signat	ure	4	1		+					

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Item 7 Per FH Film G767 1-19-99 Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month Year BILL 14 4 XM 1999 /Medical 4e. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Dealt Examiner Good Sanday 1 Age (In yrs. lest birthday)

1 M 2 F 94 A Yrs. Baltimore
If Under 24 Hrs. 8, Data Baltimore City 5. Social Security Number If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Hours 84 Yrs. 217-18-5502 Director Maryland Usuai Residanca of Decadant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ns 23a or 28a-f short 1 Yas 2 □ No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Coda 10g, Citizen of Whet Country? 1655 BURNWOOD ROAD 21239 Completed by Funeral U.S.A. Pages 1 and 2 should be filed within 72 hours efter deal neat of Heelih and Mental Hyglene.
Int: If ferm 27 is marked other than "naturel", or Hems 2 mty or other traumatic event, its Mental Examine mity or other traumatic event, its Mental Examine mity or other traumatic event, its Mental Examine mity or other traumatic event, its Mental Examine mit 12. Was Decedant Evar in U,S. Armed Forces? Was Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - Amarican Indian, Black, White, atc. 1 Yas 2 Xo
If Yas, Give X
Year or Datas: 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify: Specify: AFRO-AMERICAN 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada complated) 18e. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) Collaga (1-4or 5+) 6TH N/A DOMESTIC PRIVATE HOMES 17. Fether's Neme (First, Middla, Last) 18. Mothar's Name (First, Middla, Maldan Surnama) SIMON WARNER MARY 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) BALTIMORE, MD. 21239
Data 20c. Location - City or Town, State CATHERINE HARRISON / DAUGHTER 1655 BURNWOOD RD. 20b. Placa of Disposition (Nama of camatary, crematory or other placa) 20a, Mathod of Disposition 1 Burial 2 Cremation 3 Ramoval from Stata permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Othar (Specify) BALTIMORE NATIONAL CEM. JAN. 20, 1999 BALTO, MD. 22. Nama and Address of Fecility CALVIN B. SCRUGGS FUNERAL HOME 21. Signature of Funaral Sarvice Licans ·1412 E. PRESTON STREET BALTO, MD. 21213 23a. Part1. Entar the disease, or complications that caused the chalf. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feilure. List only one cause on each line. Approximata Interval Between Onset and Daath **Physician** Cere bro nojular l'sease /Medical Immediata Causa (Final disaase or condition rasulting in daath) Examiner Examiner buriel-transit Sequantielly list conditions, if any, leading to Immadiata causa. Entar Underlying Couse (Disaasa or Injury that initiated avents rasulting in deeth) Last Physician/Medicai the Dua to (or as a consequence of): USB BS 1 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 Probably 4 Dunknown Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Be 25. Was casa rafarrad to madical axaminar? 26. Placa of Deeth (Check only ona) Other: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Other (Specify) 1 Yas 2 Certification: To 1 ☐ Inpatient 2 ☐ PMOutpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural 5 Pending 1 | Yas 2 | No Invastigation 2 Accidant 6 Could not be 3 Sulcida 28f. Location (Straat and Number or Rurel Route Number, City or Town, Stata) Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 4 Homlcide

The law requires that the death certificate be executed Box 68760, P.O. Records, Division of Vital ş

been signed by the atter should be deteched for page 2 certificate or Attanding Physician: this funeral After 24 hours efter death. completely filled in by Hospital within 2 To the

and

death

21215-0020

Maryland

Baltimore,

State Registrar

Medical

29e. Certifian

(Check only one)

29b. Signaturo and titla of cartiflar

30. Neme and addrass of person who complated cause of daeth (Itam 23a) (Type, Print) 31. Dete filed (Month, Day, Yaar) JAN 191999

Mur E

32. Ragistrar's Signature

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1 Cortifying Physician: To the best of my knowledga, daath occurred at the tima, data and place, and dua to tha cause(s) end menner es steted.

2 Medical Examiner: On tha besis of axamination and/or investigation, in my opinion, death occurred at the time, dete and piece, and dua to tha cause(s) end mannar statad.

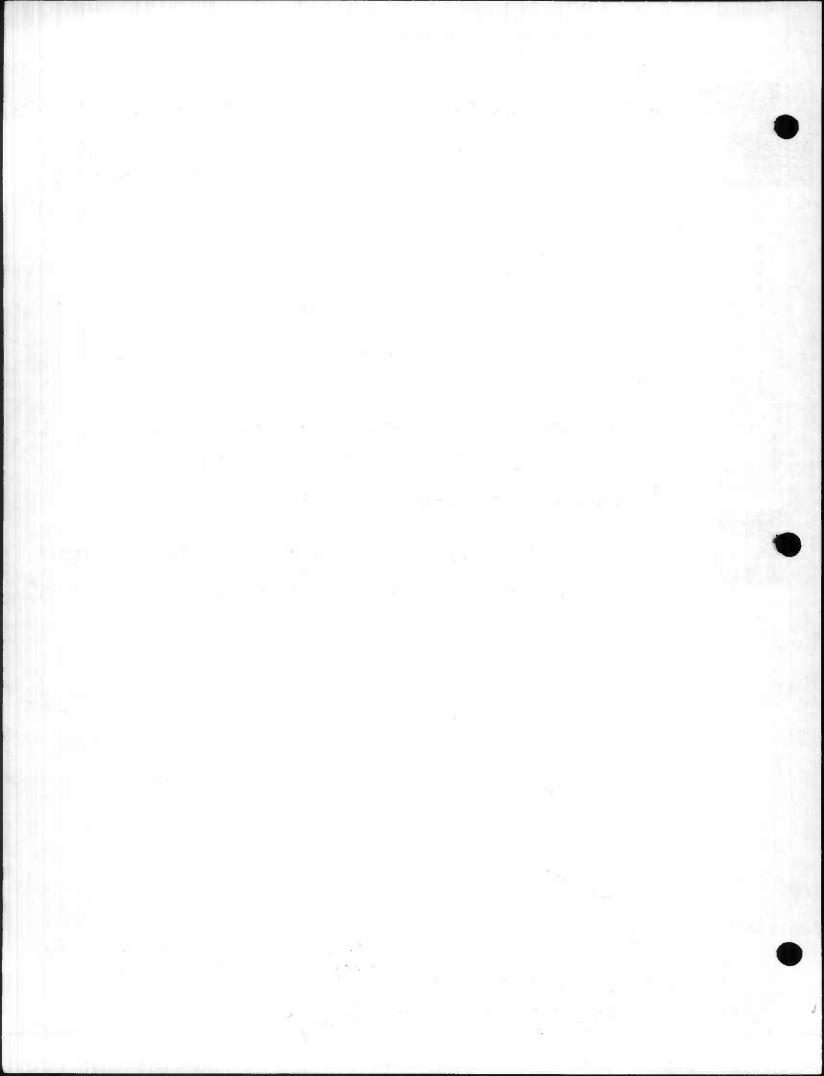
29c. Licansa number

29d. Date signed (Month, Day, Year)

HARTORD POAR

· MARRICALD

**DHMH 16 Ray 6/95** 



#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (Firşt, Middle, Last) 2. Dete of Death 3. Time of Death Month Year Barr 17,1999 11:10 pm JANUARY 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Hospita Baltimore (en) Har bor If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Days Months Hours 1 M 2 XF 212-74-6305 39 FEB 2, 1959 MARYLAND Uauel Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No ANNE ARUNDEL GLEN BURNIE MARYLAND 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1103 ROSEDALE AVENUE 21061 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Merital Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) NEVER WORKED NEVER WORKED 18. Mother's Name (First, Middle, Maiden Sumame) HOPKINS

filed within 72 hours after Hygiene. Wer then "netural", or its Baltimore, Maryland 21215-0020 Pages 1 and 2 should be nent of Health and Mental on the next of Health and Mental on the Health and New ST is marked or Department of Health as Important: If Item 27 is any Injury or other trau

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

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Barra 23a

must be notified at

Directo

Funeral

the Maryland

**Physician** /Medical Examiner

the death certificate be executed

Box 68760,

P.O.

Records,

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physician and s the buriel-transit 80 ò the signed by t page 2 has director.

Examiner Physician/Medical ò Completed Certification: edicai

Division of Vital I or Attending Physician: this death. Director: To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by hours after

> State Registrar

à Completed 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 17. Father's Neme (First, Middle, Last) Be AUDREY **GEORGE** н. BARRETT 19a. Informant'a Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARRETT (FATHER) 1103 ROSEDALE AVENUE, GLEN BURNIE, MARYLAND 21061 **GEORGE** 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK 1/20/99 GLEN BURNIE, MARYLAND 21. Signeture of Futeral Service 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A. 1 SECOND AVE. S.W., GLEN BURNIE, MARYLAND 21061 23a. Pert1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on eech line. Approximete Intervel Between Onset end Death myeloid Leukemin Immediate Ceuse (Finel disease or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) thet initiated events resulting in death) Last Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Was en autopsy parlormed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 1 Wetural

Years

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore

29d. Date signed (Month, Day, Year)

Hanover St. 3001 HOROBYSKI mp JAMES 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture JAN 1 9 1999

30. Name and address of person who completed/cause of death (Item 23a) (Type, Print)

5 Pending

6 Could not be determined

2 Accident

4 ☐ Homicide

29b. Signature and title of certific

3 ☐ Sulcide

29a. Certifier (Check only one)

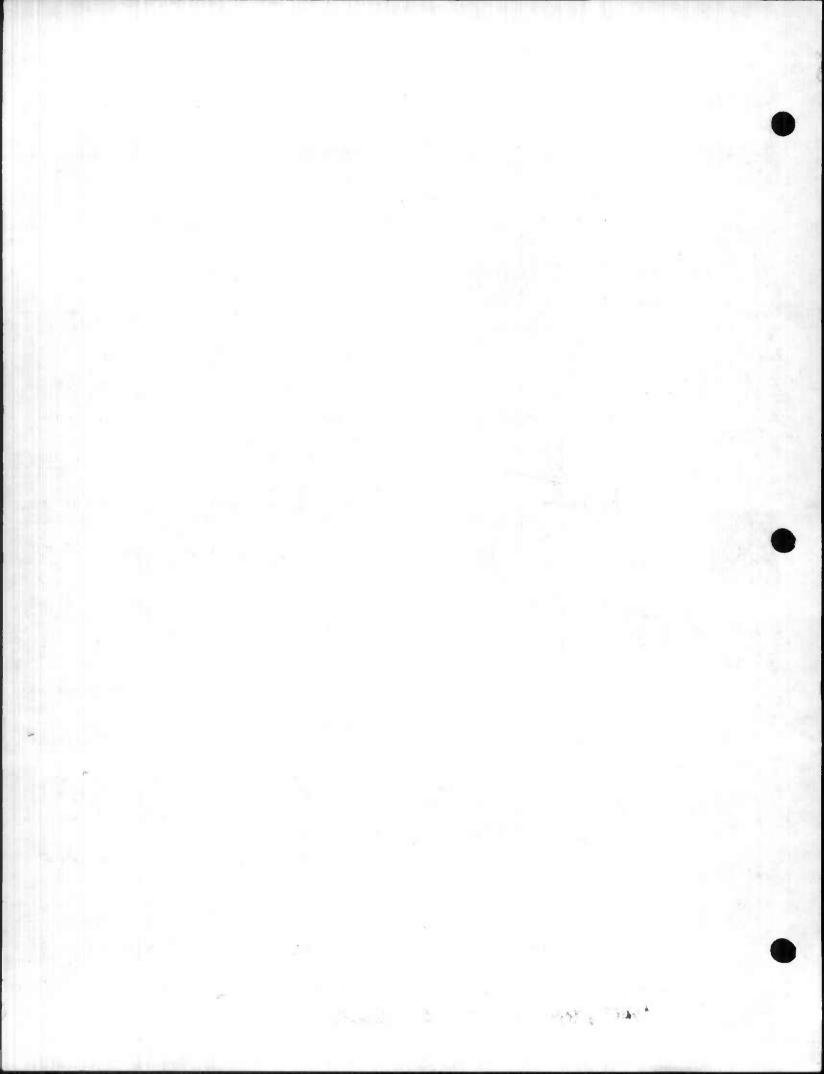
DHMH 16 Rev 6/95

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

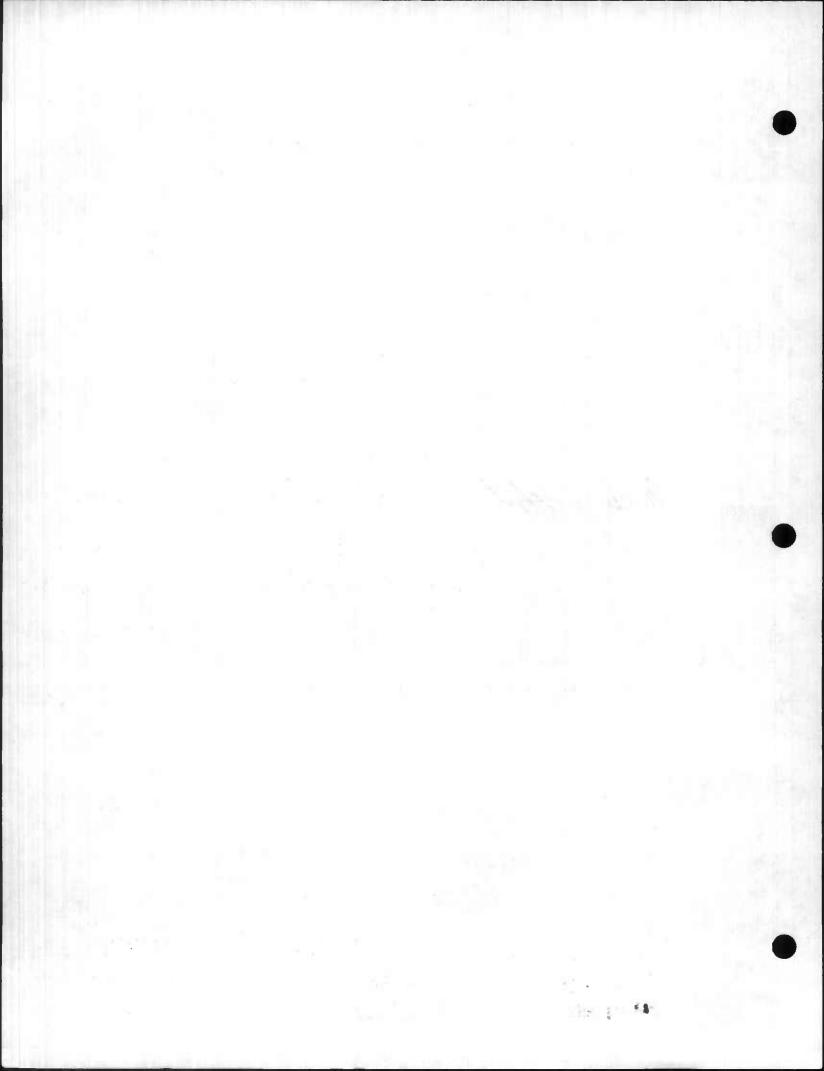
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29c. License number



		State of Marylan	Certifica				Reg. No.	00695			
Physician	Decedent's Name (First, Middle, Last)	- Broyles				2. Dete of De Month	Dey	3. Time of Death 4:02an			
/Medica Examine	0.11			T	4b. City, Town, or I	ocation of Deatl					
	NORTH ARUNG			(	GIEN BU			COUNTY			
Funeral Director	5. Social Security Number 6. Sex 1214-40-8536	7. Age (In yrs. 56		der 1 Year ns Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da MAY 24,	1942	Birthplace (State or Forei Country)     MARYLAND			
bur Bu	10a. State 10b. County	10c. Cit	y, Town or Location					10d. inside City Limit			
the Maryla 28e-f shor notified at	MARYLAND ANNE ARUN	DEL	GLEN BURN	IE				1 □ Yas 2 10 N			
or 28a-f s be notified	10e, Street and Number		101.	Zip Code	TEA		10g. Citizen of V	Vhet Country?			
		O Mas Danidas Francis II	6 42 Wee De	21061			U.S.	A . e - American Indian,			
SED 020 un atter death ist, or terms 23 harriphe, man	11. Marital Status 1  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Evar In U Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas;		pecify Cub	Hispanic Origin? (S) an, Mexican, Puerl Specify:	Rican, etc.)	Bled Specify	k, White, etc.			
		atlon	16a. Decedent's U	suai Occuj	pation during most of wor	kina	16b. Kind of Bu	usiness/Industry			
C); Ay	(Specify only highast grada Elementery/Secondery (0-12)	Collega (1-4or 5+)	life. DO NO	T use retire	d)	nwy					
			SUPERVIS	OR	18. Mother's Nen	na /First Middle	-	RE AIR COIL			
Maryland Maryland 62 should be file file marked other treatmetic event		T.ES			ANNA	LOIS	DOUGHTY				
laryla laryla and Month and Month and Month	19a. Informent's Name/Relationship (Typ		19b. Meiling Addr	ess (Street	end Number or Ru						
200 20 20 20 20	BARBARA L. BROYLES	(WIFE)	1018 GUY	DRIV	/E, GLEN	BURNIE,	MARYLAN	D 21061			
Baltimore, semil. Pages 1 as Department of Hea meantment of Hea meantment if them into into injury or other mises.	20a. Method of Disposition 1 ☐ Buriel 2 ②Cremetion 3 ☐ Re		Place of Disposition (Incometery, cremetory of	Vame of or other pla	ce)	Dete 1/18/99	20c. Location -	City or Town, Stata			
Limor Limor Comment of Lary or o	4 □ Donation 5 □ Other (Specify)	CHI	ESAPEAKE C		ION CENTE		CHESTER	R, MARYLAND			
Bail Departiment any in	21. Signeture of Funeral Service License	The lain	SINGL	ETON	FUNERAL  AVE. S.W.			MARYLAND 210			
	23a. Pert1. Enter the disease, or complic shock, or heart failure. List only one	eatiens thet caused the deet						Approximete Intervel Between Onset and Death			
Physician /Medical Examiner	Immedieta Ceuse (Final diseese or condition resulting in deeth)	disease or condition									
		Commo		01):	Licons			( lears			
58760, icate be executed physician and a the burial-transit	Sequentially list conditions,		or as e consequence	on)	a secope			1			
Do 60 M	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events										
	resulting in death) Last	Due to (o	r es a consequence o	of):				Contract to			
Box (eath certification)	d.										
death death of for all of	Part II. Other aignificant conditions cont	ributing to death but not res	ulting in the underlyin	g cause gi	ven in Pert I.	23b. Dld	tobacco use co	ntributa to the cause of deat			
S, P.O. BOX es that the death certificated by the attending by observed for use as						10	Yea 2□ No	3 Probably 4 Unkno			
Cord requir been s should							an autopsy ormed?	24b. Were autopsy finding: available prior to completion of cause of death?			
The law ate has page 2						10	Yes 2 No	1 Yes 2 No			
	25. Wes case referred to medical exeminer?				26. Place of Dee	oth (Check only	one)	I.			
Of V Physic this ce al dire	1 Yas 2 No			DOA			dence 6 □Oth				
On On Gling P. Affect Affect funera	27. Menner of Death  1 Division 5 Panding	28e. Dete of Injury (Month, Day Year)	28b. Time of injury		ryat ork? ]Yes 2 □ No	28d. Describe	how injury occur	red			
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be 6	2 Accident investigetion 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At his building, etc. (Specification)	ome, term, street, tec				Street end Numb wn, Stete)	per or Rural Route Number,			
DIVISION To the Hospital or Attention 24 hours after deat To the Funeral Director: completely filled in by the Medical Certifical	29e. Certifier 1 Certifying Phyai (Check only one) 2 Medical Examin	ician: To the best of my knoer: On the basis of examine and menner steled.	wledge, death occurr tion and/or investigat	ed at the ti ion, in my o	ime, dete and place opinion, deeth occu	, and due to the cred et the time,	cause(s) and modete end place,	anner as stated. and due to the cause(s)			
To the within 2 To the comple	29b. Signeture and title of certifiar			29c. Licen	se number		29d. Deje signe	d (Month, Day, Year)			
	Horm	V		DZI	1480		1/78	199			
7	30. Nema and address of person who con	poleted cause of deeth (Item		1	10	10	2	100.1			
V	H. Josem	(Cim, m)	203 /2	Spip	y いい	e, ble	n Bun	4, hur) 2106			
State	31. Date filed (Month, Dey, Year)	32. Registrar's Signa	gure /	,							

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** TANF. 9:15 AM BROGNEAUX JANUARY 15, 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner 2 ANNE ARUNDEL 184 PLYMOUTH LANE, APT. # GLEN BURNTE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Dey, Year) **Funeral** Months 1 M 2 X F Days Hours PENNSYLVANIA Director 78 AUG. 4, 1920 189-22-6291 Usual Residence of Deceden the Maryland 10s State 10b County 10c. City. Town or Location 10d Inside City Limits r 28a-f show worle 1 ☐ Yes 2 XNo Director GLEN BURNIE ANNE ARUNDEL MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With "natural", or items 23s or 184 PLYMOUTH LANE, APT. # 2 21061 U.S.A. Funeral 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married Specify: WHITE Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: by 3 Widowed 4 □ Divorced r than "nature Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. HOMEMAKER OWN HOME 12 7 la marked other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Pages 1 and 2 should be 1 nent of Haalth and Mental I GAYLORD NANCY UNKNOWN THOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) item 27 l 7917 OAKWOOD ROAD, GLEN BURNIE, MARYLAND 21061 MARGARET **GEORGE** (DAUGHTER) 20b. Piace of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: if it any injury or o 1 X Buriat 2 ☐ Cremation 3 ☐ Removal from State 1/18 4 ☐ Donation 5 ☐ Other (Specify) 1999 Evergreen Memorial Park Point Marion, PA 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heef feilure. Let only or a cause on each line. Approximate Interval Between Onsel and Death **Physician** /Medical Immediate Cause (Finel SUDDEN disease or condition resulting in death) Examiner Examiner physician and the burial-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Box 68760. Sue 5 CLEUTAC Physician/Medical attending p signed by the aid be datached? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown It YPOTH PURD FSH þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed en Versesever is cartificate has director, page 2 The 1 Yes 2 No 1 ☐ Yes 2 ☐ No. Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Lo 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Dey Year) 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: After 1 Netural injury 5 Pending 1 Yes 2 No death. investigation 2 Accident after death Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aftr To the Funeral Dir completally filled in 29a. Certifier termination (a) Item Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of exeminetion and/or Investigation, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) end manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and the of certifier 29c. License number 2106 Drur GER BURE

32. Registrar's Signature

Registrar

State

demonstration of the con-The set Pay Silver, someone TELEVISION OF THE PROPERTY. 

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Gladys Ann Hough Bentley 1999 5:08 P.M. JANUARY 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death / Rosed Ale If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 17 10 Square Hospital BAITIMORE FRANKLIN Cenler 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1□M 2♥ F 56 215 40 7260 17,1942 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2√ No Maryland Baltimore Essex 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 172 Orville Rd. 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. . Was Decedent Ever in U,S Armed Forces? 11. Marifal Sfefus 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Induatry Elementary/Secondery (0-12) College (1-4or 5+) Market Researcher Oil Co. 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Mary K. Gresham Alfred J. Dillev 19a. Informant'a Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Donna Dilley (Sister) 9884 Bird River Rd. Baltimore, Md. 21220 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 XBuriel 2 Cramation 3 Removal from State Oak Lawn Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 1/16/1999 Baltimore, Md. 22, Nema end Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Durkouste 23a. Part I Enter the disease, or complications that ceusad tha death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shirts, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel . Metastatic Carcinoma to Mediastinum and Lungs 10 Months disease or condition resulting in deeth) arcinoma of the base of the Tonque Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In deeth) Last Due to (or as e consequence of) Dua to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings svallable prior to 24a. Wes an eutopsy performed? completion of cause of death? 1 Yas 2 No 2 No 25. Was case referred to medical examiner? 1 ☐ Yes 250 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 1 Neturel 2 Accident 5 ☐ Pending investigation 1 Yes 2 No

sician and burial-transit Box 68760 the Records, P.O. certificate Division of Vital this funeral After Attending

Examiner edical Physician/M by Completed Be Certification: To Hospital or Attending n 24 hours after death.
 Funeral Director: After

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be: Department of Health and Mental Important: If them 27 Is marked of

**Physician** /Medical

Examiner

Funeral

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**DHMH 16 Rev 6/95** 

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Registrar

9000 Dr. DAWN WARNER 31. Date filed (Month, Day, Year) 32. Registrar'a Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARNED

6 Could not be determined

3 Suicida

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and Mile of certified

PUARE DR. BAITIMORE, MARYLAND 21237 FRANKlin

29c. License number

28e. Place of Injury - At home, ferm, afreet, fectory, office building, etc. (Specify)

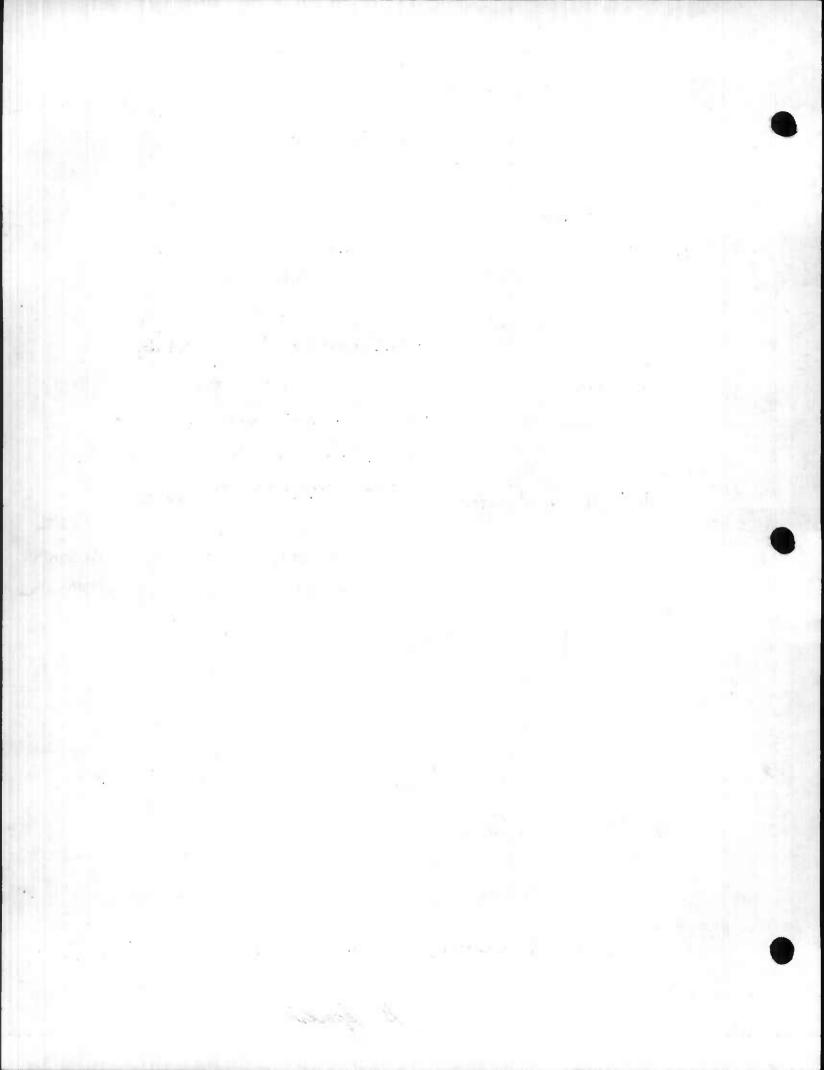
**ORIGINAL** 

29d. Date signed (Month, Dey, Year)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) manner stated.

281. Location (Street and Number or Rurel Route Number, City or Town, Stete)



State of Maryland / Department of Health and Mental Hygiene

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CHARLES BA	AN.	KS	State of Wi	ai yiai				Death	Wiental 11	Reg. No.	U	0698		
Physicia	_	1. Decedant's Nama (First, Middle, La		BANK	VC				2. Data of D Month JAN	Day 15, 199	Year	3. Time of Death 0735 AM		
/Medica Examine	_	4a Facility Name (If not institution, giv 2908 NORTH LOUI	a street and number)		,,,			4b. City, Town, or BALTIM	Location of Dea					
Funeral Director		214-22-0160	ex 7. Ag	a (In yrs.	last birthday) 67 Yrs.	If Und Month	er 1 Yaar s Days	If Under 24 Hrs Hours Min		irth lay, Yeard 9, 1931	9. Birthe	place (State or Foreign http) YIANA		
Maryland f ahow		Usual Rasidance of Decedent  10a. Stata  10b. County  Mayuland  NA		-	ty, Town or Lo				1,11	0.0	1	10d. Inside City Limits 1 ☑ Ves 2 ☐ No		
death with the Maryland rms 23s or 28s-f show f must be notified at	Funeral Director	10e. Street and Number 2908 N. Loudor	n st.	15.1		10f. Z	ip Code 2/2/0	10		10g. Citizen of V	Vhat Cour	ntry?		
9 22	by Funer	11. Marital Status  1 □ Navar Marriad 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forcas? 1 Yas 2 I If Yas, Giva Yaar or Datas:				edent of lecify Cub	lispanic Origin? (S an, Mexican, Puar Specify:	Specify Yas or N to Rican, atc.)		14. Race - American Indian, Black, Whita, atc.  Specify: Black			
A 12.15-UOZU d within 72 hours efter jiene. rr then "neturel", or he re theories Exercise	Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)	ducation	5+)	tife.	kind of v DO NOT	vork done use retire	during most of working						
262	To Be Col	17. Fether's Neme (First, Middle, Last,  James 13	PanKs		Hor	emo		18. Mother's Ne	. 1	e, Maiden Sumam				
Mith and 27 is my r treum		19a Informant's Neme/Relationship ( ROSA Lee R. BAI			2908	N.	Lou		POUL BA	ber, City or Town,  AH, MD.	212	16		
Pages nent of ant: If its ury or o		20a. Mathoe of Disposition 1 ☑ Buriel 2 ☐ Crametion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	1	Place of Dispo cemetery, crea	matory of	other pla		1/20/99	20c. Location -				
permit. I Departm Importar any injur		21. Signature of Funaral Sarvice Licensee  22. Nama and Address of Facility Kevin A. Marker Funeral Hab  Solution Forest Cemetery 120/99 Owings Mills  22. Nama and Address of Facility Kevin A. Marker Funeral Hab  Solution Facility Revin A. Marker Funeral Hab  Solution Facility Revin A. Marker Funeral Hab  35/12 Frederick Avenue  23a. Part 1. Enter tha diseasa, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approx												
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Arteriosclerotic Cardiovascular Disease  Due to (or as a consequence of):											Intarval Between Onset and Death		
ficate be executed physician and is the burial-transit	Examiner	Sequentially list conditions, if any, laading to immediata causa. Entar Underlying Cause (Disease or injury	b	Due to (	or es a consec	quence o	r):							
	edical	Cause (Disease or injury that initiated events rasulting in death) Last	d	Dua to (or as a consequence of):										
that the death certified of by the attending detached for use a	Physician	Part II. Other algnificant conditions o	ontributing to death b	ut not res	sulting in the u	inderlying	cause gi	ven in Part I.	23b. Die	i tobacco usa co	ntributa t	uta to the cause of death?		
ires that the signed by the	by Pmy								10	Yes XXNo	3 Pro	obably 4 Unknown		
law requires that las been signed be dete	Completed								per	s an autopsy formed? FCTION	80	Vere autopsy findings vailable prior to completion of cause i death?		
The law										Yes \$\text{XNo}	11	□ Yes 2□ No		
ding Physician: The law require h. After this certificate has been si funeral director, page 2 should	0	25. Was casa refarred to medical axaminar?  XXX Yas 2 □ No  27. Mennar of Death  1 XX tural 5 □ Panding	Hospital: 1 Inpatie	ry	ER/Outpatier 28b. Tima o Injury	f	28c. Inju Wo	ner: 4 Nursing ny at nk?	2 12 1	sidence 8 Oth how injury occur		fy)		
To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	enilicati	2 Accident 3 Suicide 6 Could not b datarmined				M reet, facto		Yes 2 □ No	28f. Location City or To	(Street and Numb own, State)	er or Run	al Route Number,		
Hospity 24 hours Funera stely fille	edical		ysician: To the best of the part of the pa	axamina										
To the within To the comple	ē F	29b. Signatura and titla of certifiar	Kirkm	0		2		.C.M.E		29d. Data signe				
0		30. Name and address of person who Theodore Kinj 11.					reet,	Baltimo	re, Mar	ylani 21	201			
State Registra		31. Data filed (Month, Day, Year)	32. Registr	ar's Sign	atura &	1	bour	41				4		

DHMH 16 Rav 6/95

**ORIGINAL** 

physician and s the burial-transit The law requires that the death certificate be executed peen has certificate or Attanding Physician: this efter death. hours e

as esn signed by the a director. funeral Director: After the in by the funers To the Hospital within 24 hours e To the Funeral C npletely

**Physician** 

/Medical

Examiner

Director

Funeral

à

Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, it a Magical Examiner must be notified at

should be filed within 72 hours after death and Mental Hygiene. marked other than "natural", or items 23.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If fem 27 is marked othe any Injury or other traumatic event, DDGs.

**Physician** 

/Medical

Examiner

Examiner

Baltimore, Maryland 21215-0020

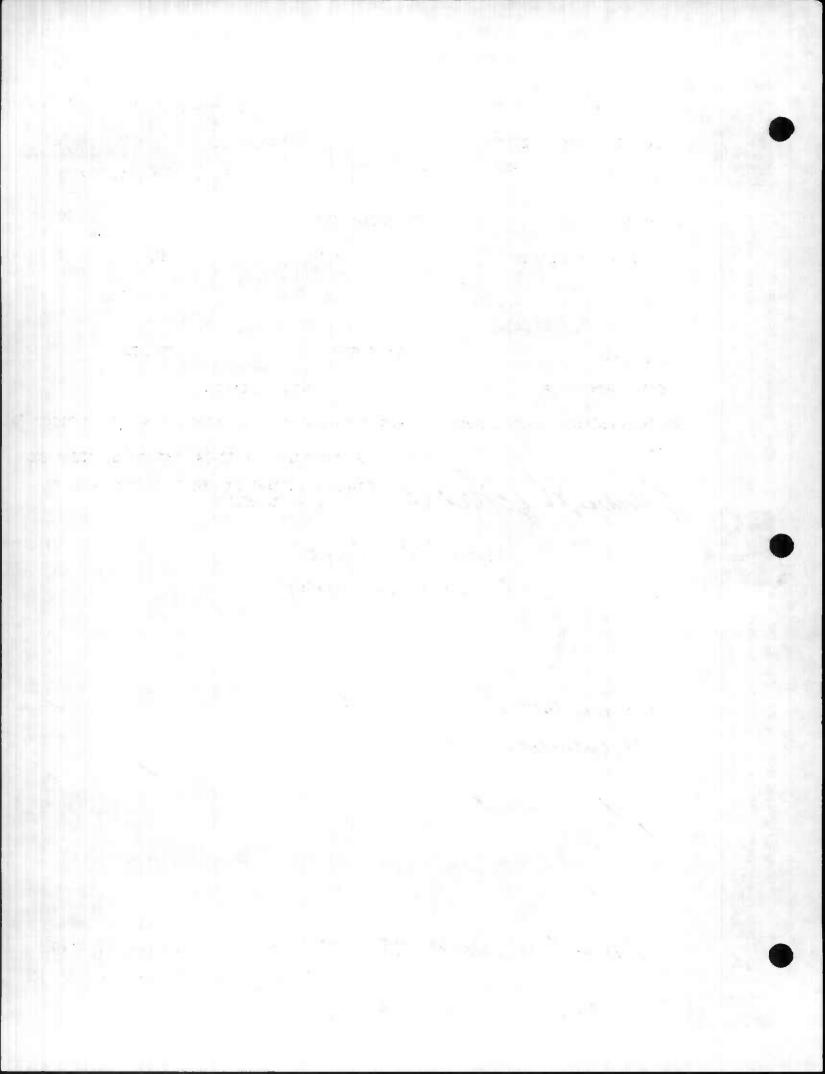
the Maryland

with

Registrar

Physician/Medical ð Completed 25. Was case referred to medical exeminer? Be 1 Yes 2 No P 27. Menne of Death Certification: 1 (DNaturai 2 Accident 3 ☐ Suicide 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) il M M.D. January 17, 1999 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 2600 Liberty Heights Avenue 21215 Jedrae

32. Register's Signature 9 1999



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Margaret B. Copper January 13, 1999 6:00 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not Institution, give street end number) Examiner Gilchrist Center Towson Baltimore If Under 24 Hrs. If Under 1 Year Birthpleca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Deys Hours Min 1 M X F Yrs. 220-12-8899 93 7-21-1905 **Director** Pennsylvania Usuei Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f ahor traumatic event, the Mazical Examiner must be notified at Maryland Baltimore Towson 1 ☐ Yes 2 □XNo Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 305 E. Joppa Road, Apt 1409 21286 U. S. A. Funerai 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Merital Status Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: à White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 16e. Decedent's Usuel Occupetion during most of working (Give kind of work done do life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health end Mentel Hygiene. ant: if item 27 is marked other than " College (1-4or 5+) Elementary/Secondery (0-12) Orphanage House Mother 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) William Julia McGovern Kelly 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Mr. Lloyd Copper (Son) 225 Arundel Road, Pasadena, Maryland 21122 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Department of Important: If it any injury or o Marial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Moreland Memorial Park 1-18-99 Parkville, Maryland 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Wallac Ruck Towson Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. 1 1050 York Road, Towson, Md. 21204 Intervel Between Onset end Deeth **Physician** multi-organtai Immediete Ceuse (Finel diseese or condition resulting in death) /Medical 5 days Examiner 5 days Examiner syndrome Sepsis ettending physician and for use as the buriel-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Box 68760. certificate be Physician/Medicai thet initieted events resulting in deeth) Lest Due to (or es e consequenca of): deeth ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed t Records, ò requires 24e. Wes en eutopsy performed? 24b. Were autopsy findings aveileble prior to Completed Deen completion of cause of death? Mel certificate hes The 200 No 1 ☐ Yes 2 ☐ No Division of Vital Attanding Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 2 After this funeral 28e. Dete of injury (Month, Dey Year) 27. Manner of Deeth Certification: 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending 1 Neturel 1 Yes 2 No death. Investigation 2 Accident or Attand after death Director: 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suiclde 28f. Location (Street end Number or Rurel Route Number, City or Town, State) filled in by 4 I Homicide 24 hours a Funeral D 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end menner stated. 29a. Certifier edicai completely (Check only one) within 2 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie und death (Item 23e) (Type, Print)

GBMC

32. Registrar Signeture

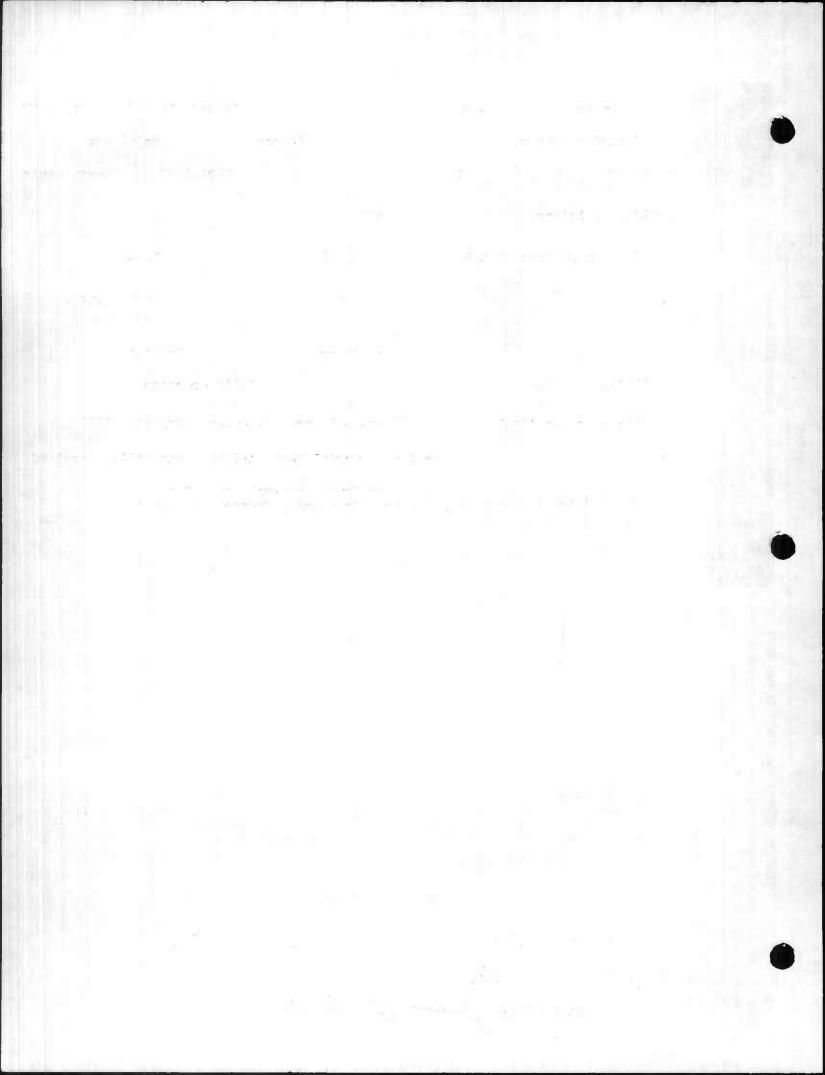
State Registrar

**DHMH 16 Rev 6/95** 

Margaret Copper /13/99

1999

6701 N. Charles St. Bolto Md 2120x



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 3. Tima of Death 1. Decedant's Nama (First, Middle, Last) **Physician** 1999 Crossler 4:20 AM nomas 17 January · /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center
5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) n/a Baltimore if Under 24 Hrs.
Hours Min.
Min.
March 22, 1916 If Under 1 Year Birthplaca (Stata or Foreign Country) **Funeral** Days 10XM 20 F 180-01-8906 Yrs. 82 MAryland **Director** Usual Rasidenca of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inaide City Limits r than "naturel", or items 23s or 28s-f show the Medical Example: must be notified at Baltimore Middle River Md. 1 ☐ Yas A☐ No Director 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 27 Coolbreeze Drive 21220 USA death y Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. filed within 72 hours after 1 □Yas 2 □ No If Yes, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 X☐ No Specify: White g 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedant's Education (Spacify only highast grade completed) 16a. Decadant's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Coilaga (1-4or 5+) Engineer Conrail-Railroad 8th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any linjury or other traumatic event, page. 18. Mothar's Name (First, Middla, Meidan Surnama) 17. Fathar's Nema (First, Middla, Last) Unit Foster Crossley Dorothea Emila Magdalina Hiltz 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 701 Cassel Road #64 Manchester PA. 17345 Thomas L. Crossley /son 20a. Method of Disposition 20b. Place of Disposition (Neme of camatary, cramatory or other place) Data 20c. Location - City or Town, State 1 Burlal 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) DulaneyValleyCemetery 1/20/99 Baltimore Md. 21. Signatura of Funarai Sarvice Licenses 22. Nama and Addrass of Facility Connelly Funeral Home of Essex 23a. Perti. Entar the disease, or complications that caused the death of point antar the mode of dying, such as cardiac or respiratory arrast, shock, or heert feilure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediata Ceusa (Final disaasa or condition resulting In daath) Pneumonia I WK Examiner Dua to (or as e consequance ot): 45 Physician/Medical Examiner Dementia ettending physician end for use as the buriel-transit The law requires that the deeth certificate be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence ot): Due to (or as a consequanca of): 8 signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 2 No 3 Probably 4 Unknown Atrial Fibrillation à 24b. Wera autopsy findings available prior to complation of cause of daath? should 24a. Was an autopsy performed? Completed hes e 2 ebed 1 Yas 2 No 1 Yas 2 No this certificate director. 25. Was casa referred to medical Be 26. Placa of Death (Check only ona) axaminar? Hospital: Othar: 4 ☐ Nursing Home 5 ☐ Rasidanca 8 ☐ Other (Specify) 1 Yes 2 No 2 1 inpatiant 2 ER/Outpatient 3 DOA 28c. Injury at Work? funeral 27. Menner of Deet 28b. Tima of 28d. Describe how injury occurred Certification: 1 Natural 5 Panding invastigation 1 ☐ Yes 2 ☐ No 2 Accidant Director: / 3 Sulcida 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of fnjury - At home, farm, street, factory, offica building, atc. (Spacify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. edical 29e. Certifier (Check only one)

Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica in 24 hour. the Funeral Direction

altimore, Maryland 21215-0020

Box 68760.

31. Dete filed (Month, Day, Yeer)

Sec

29b. Signature and title of certifier

mo. 4940 Eastern ATC 32. Registrar's Şignatura

30. Nama and address of person who complated causa of daath (Itam 23a) (Type, Print)

29d. Data signed (Month, Day, Year)

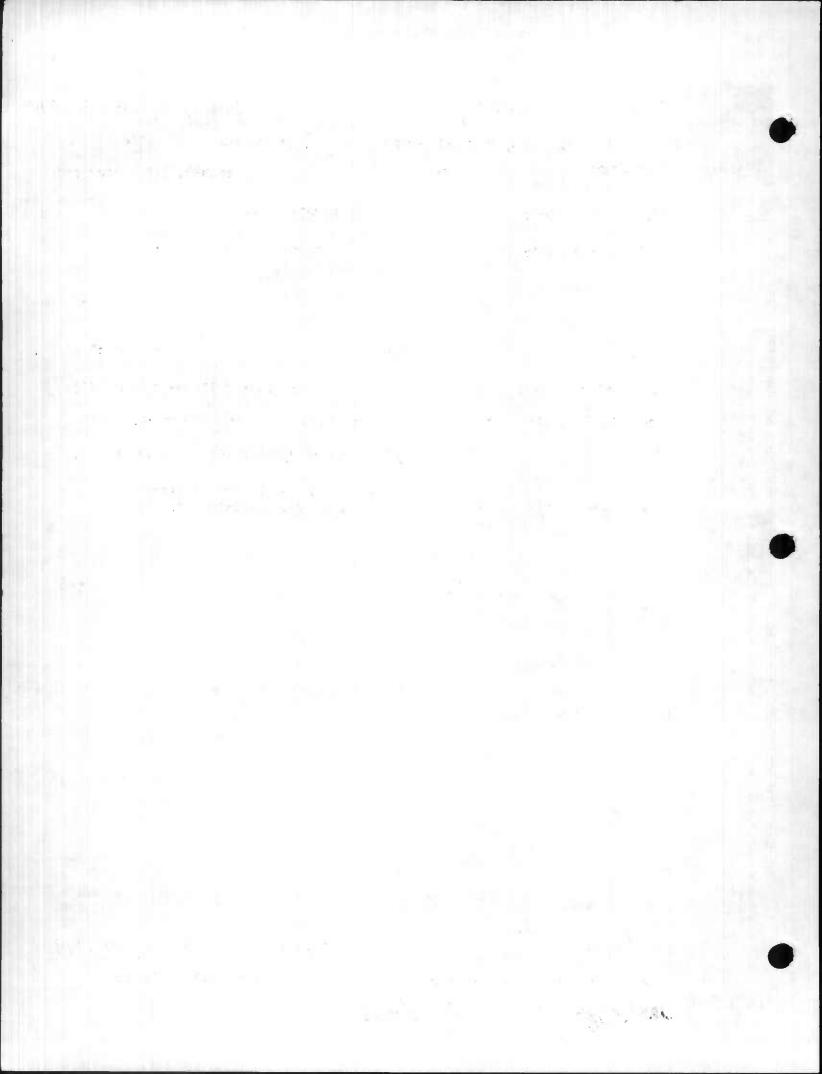
21224

lanuary

Baltimore, MD

Registrar

State



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1045 **Physician** 6 JANUARY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number 4c. County of Death Examiner more If Under 1 Year 5. Social Security Number 216-50-29 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign A Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 216-50-293 Usual Residence of Decedent 1□M 200 F Mary Yrs. Director Jan.d lana 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow Mary land 1 Yes 2 □ No Director timor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mass or 2 SA 12 23 Funeral 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Black, White, atc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiens. 1 Never Married 2 Married 1 ☐ Yes 2 ⊠ No If Yes, Give Year or Dates: 6 1 Yes 2 No Specify: by ATTO 3 Widowed 4 Divorced -Hmericar Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 90 0 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 10 (Friend 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 0 If hem 27 altimore. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cramation 8 3 Removal from State permit. Page Department of Important: If eny injury or once. 20 4 ☐ Donation 5 ☐ Other (Specify) or Cemeter 22. Name and Address of Facility Joseph L, Rus ZZZZ W, North 21. Signators of Funeral Service License unera Ave. 21216 is or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, that only one cause on each line. Approximate Intervel Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician sthe burial Box 68760. Physician/Medical Due to (or as a consequence of): for use es signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 2000 1 ☐ Yes 2 ☐ No certificate Division of Vital Attanding Physician: funeral director, 25. Was case referred to medical axaminer? Be MARIS AT MERC 26. Place of Death (Check only one) Stell A Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE edical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? After 5 Panding investigation 1 Natural 1 Yes 2 No r death. 2 Accident within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicida Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the ! 29b. Signature and filte of certifier 29c. License number 29d. Date signed (Month, Day, Year) to SANUARY 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) RISE DERG

State Registrar

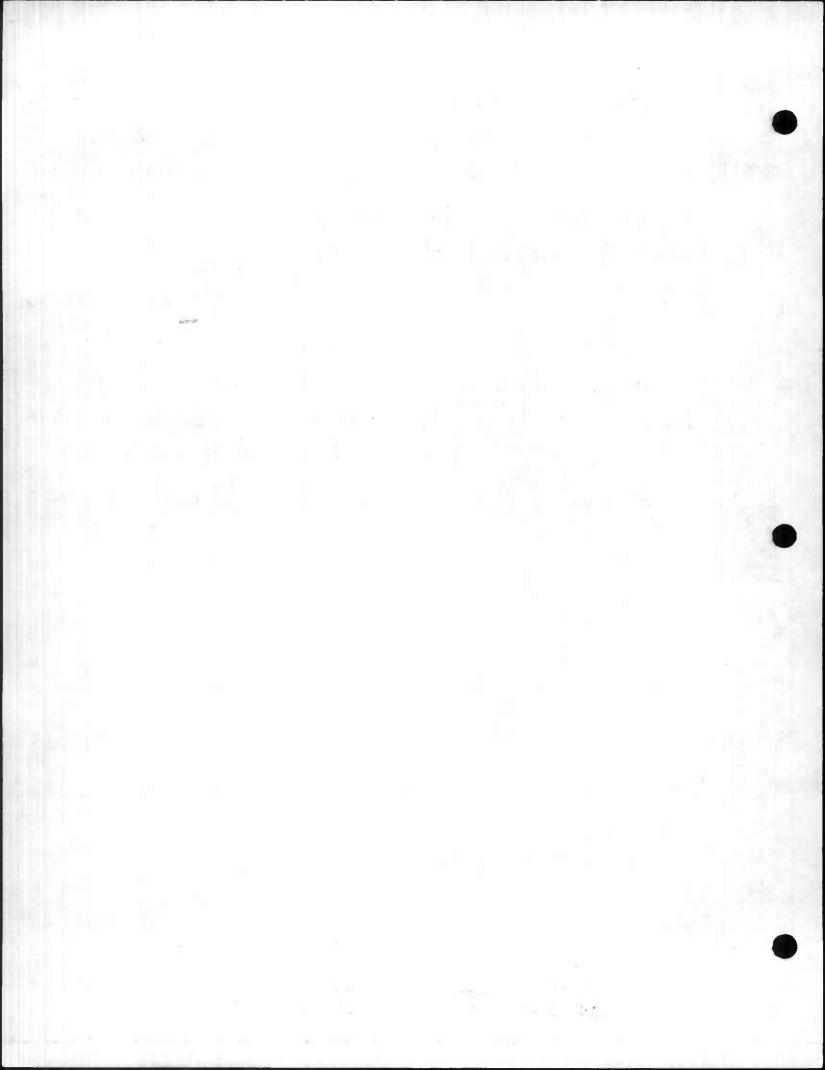
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32. Registre & Signature

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31. Data filed (Month, Day, Year)

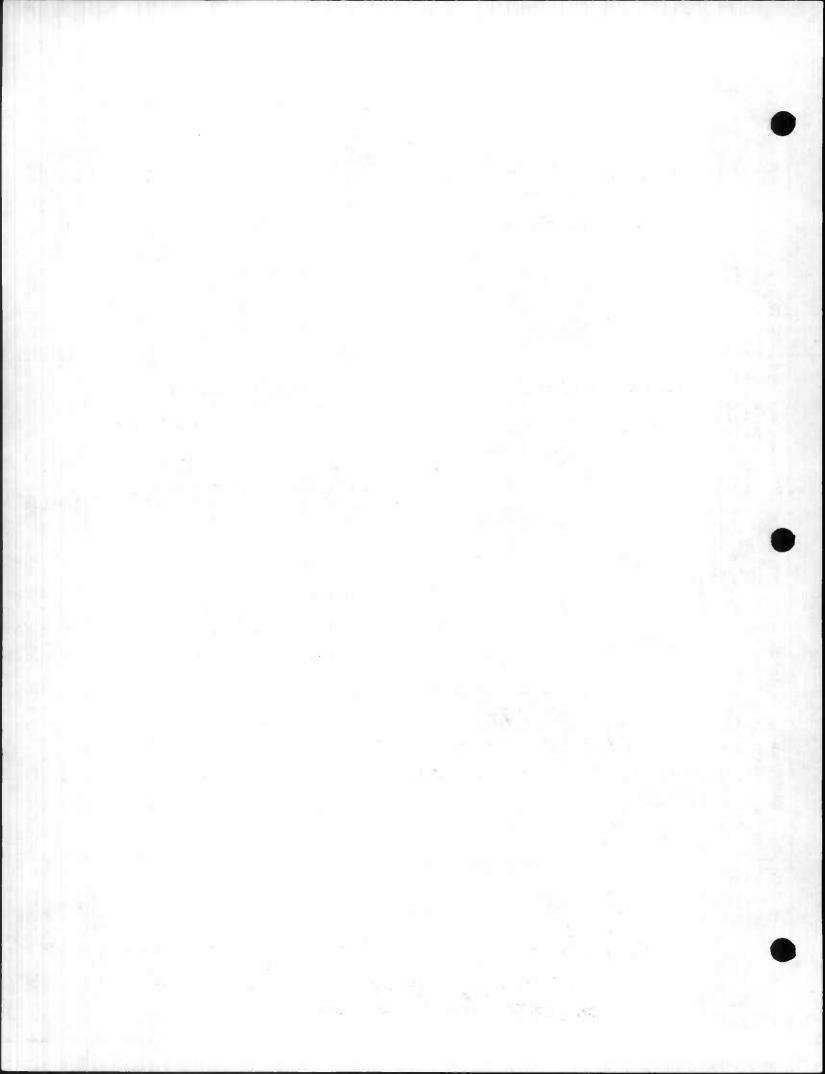
1 9 1999

32 Registrar's Signatura

Journal of the Willer of the Language Street Court Sugar AND THE CONTRACT OF THE PROPERTY OF THE PROPER to the universe the control of the second war hipsening 

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. No. 99 00704
Physician /Medical	1. Decedent's Name (First, Middle, Last)  As Facility Name (If not institution, give street and number)	CARSON 2. Date of Month	NURY 16,1999 11:17
Funeral Director	HARBOR HOSP. C.  5. Social Security Number 215-01-2820  6. Sex 1□ M 20 F  7. Age (In yrs. last b) 86	ENTER BALTINI  inthday) If Under 1 Year If Under 24 Hrs. 8. Date of Months Deys Hours Min. (Month)	N/A  N/A  Sirth, Pear)  Sirth, Day, Year)  Sh. 2, 1912 Maryland
show show		wn or Location	10d. tnside City Limits 1 □ Yes 2/□ No
efter deeth with the Meryland or lisms 23s or 28s-f show minst must be notified at Funeral Director	Md.   Anne Arundel   Balt 10e. Street and Number 5300 Patrick Henry Drive	imore   101. Zip Code   21225	10g. Citizen of What Country?
5 F 5	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Wes Decedent Ever in U,S. Armed Forces?  1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc	or No- 14. Race - American Indian, Black, White, etc.  Specify: White
ed within 72 hours ygiene. her than "natural", f, the Medical Ex Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  6th  0	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Homemaker	16b. Kind of Business/Industry Home
## # B .	17. Father's Name (First, Middle, Last) Thou ias Dobrochowski	18. Mother's Name (First, Mi	
2 should by end Mente le marked reumatic e	19a. Informant's Name/Relationship (Type, Print) 19	b. Mailing Address (Street and Number or Rural Route N	lumber, City or Town, State, Zip Code)
y or H	20a. Method of Disposition  1 Derial 2 Cremation 3 Removel from State	0940 Holt Court Denton, Ma of Disposition (Name of ery, cremetory or other plece)  Haven Memorial Park 1/20/9	20c. Location - City or Town, State
pemit. Pe Departmen Important: eny Injury snes.	21. Signature of Funeral Service Licensee	McCully-Polyniak Funeral	Home P.A.
Physician /Medical Examiner	23a. Part Lenter the disease, or complications that caused the deeth. Do shock, or heart tailure. List only one cause on each line.  Immediate Cause (Finel disease or condition resulting in death)	5/5	tnlerval Between Onset and Death
seth certificate be executed stending physician and for use as the buriel-fransit clary/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a consequence of):  FAILURE  a consequence of):  ARY ARTERY Consequence of):  VE SMALL BC	S day
of the distribution of the	Part II. Other significant conditions contributing to death but not resulting  PERIPHERAL  VA	in the underlying cause given in Part I. 23b.	Did tobacco use contribute to the cause of dear
The lew requires the sate has been signed, page 2 should be Completed by	DIABETED MEL		Was an autopsy performed?  24b. Were autopsy finding available prior to completion of cause of death?
Pege Po	HYPERTENSION		1 Yes 2 No 1 Yes 25 No
2 00 2	25. Was case referred to medical axaminer?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/O  27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		Residence 6 Other (Specify) ribe how injury occurred
RESE T	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, 1 building, etc. (Specify)	farm, street, fectory, office 28f. Locat City of	ion (Street and Number or Rural Route Number, or Town, State)
To the Hospital of within 24 hours of To the Funeral D completely filled I completely filled I Completely filled I Completely filled I Completely filled I Completely filled I Completely filled I Completely filled I Comp	29a. Certifier (Check only 2 Medical Examiner: On the basis of examinetion a and manner stelled.	pe, death occurred at the time, date end place, and due to nd/or investigation, in my opinion, deeth occurred et the t	the cause(s) and manner as stated. ime, date and place, and due to the cause(s)
Vithin To the compl	200. Signature of the of contine	29c. License number D 2 8 9 8 8	29d. Date signed (Month, Day, Year)  Vanuary 16, 1999
15	30. Name and address of person who completed cause of death (Item 23a)		4. Ball. MD 2122
State Registrar	31. Date filed (Month, Day, Year) 32. Registre's Stoneture	B. Sporks	



Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Physician January 13, 1999 Eugene Clarence Cobb, Jr. 12:50 pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner St. Agnes Hospital Baltimore If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 8. Data of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1X M 2 F Months March 11, 1940 Virginia Director 220-36-9882 Usual Residence of Deceden the Maryland 10c. City, Town or Location 10d. fnside City Limits 10a State 10b County 1 and 2 should be filed within 72 hours aftar death with the Maryla Haalih and Mental Hygiena. en 27 is marked other than "naturat", or frams 23a or 28a-f show the traumatic event, it is welfall Exc. it as now to not the 1X Yes 2 No Director Md. N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2635 Wilkens Avenue 21223 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Biack, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: py 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) 9th 0 Union Printer John D. Lucas 18. Mother's Name (First, Middla, Maidan Surname) 17. Father's Name (First, Middle, Last) Eugene Clarence Cobb, Sr. Hazel Mae Houlihan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Sandra Lee Gemeny ( Daughter ) 44 Atlantic Avenue Salisbury, Maryland 21804 of Haalth other t Baltimore, 20b. Piaca of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State permit. Pagas 1
Department of H
Important: If Iter
any Injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Memorial Gardens 1/16/99 Marriottsville, Md. McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Servica Licensee The 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in daath) /Medical a End Stage of Renal Failure Examiner 5 years Due to (or es a consequence of): Examiner Pulmonary Fibrosis 8 years physician and the bunal-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Due to (or as a consequence of): Box 68760. Hypertension 10 years Physician/Medical Due to (or as a consequence of): 88 Neutropenia 985 5 days P.O. | signed by the a 23b. Did tohecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No 3 Probably 4 Unknown Vital Records. ò 24b. Wera autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? certificate has been s rector, page 2 should Completed The law 1 No Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case rafarred to medical examiner? Be 26. Placa of Death (Check only ona) To Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Division of Athar This 28a. Date of Injury (Month, Day Year) uneral 27. Manner of Death 28b. Time of Injury 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 20 24 hours Funeral 1 Certifying Physicien: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) Within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier D0052540 January 14, 1999 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

, Stangnes HealthCare, 900 Caton Ave., Baltimore, Md. Registrar Signature

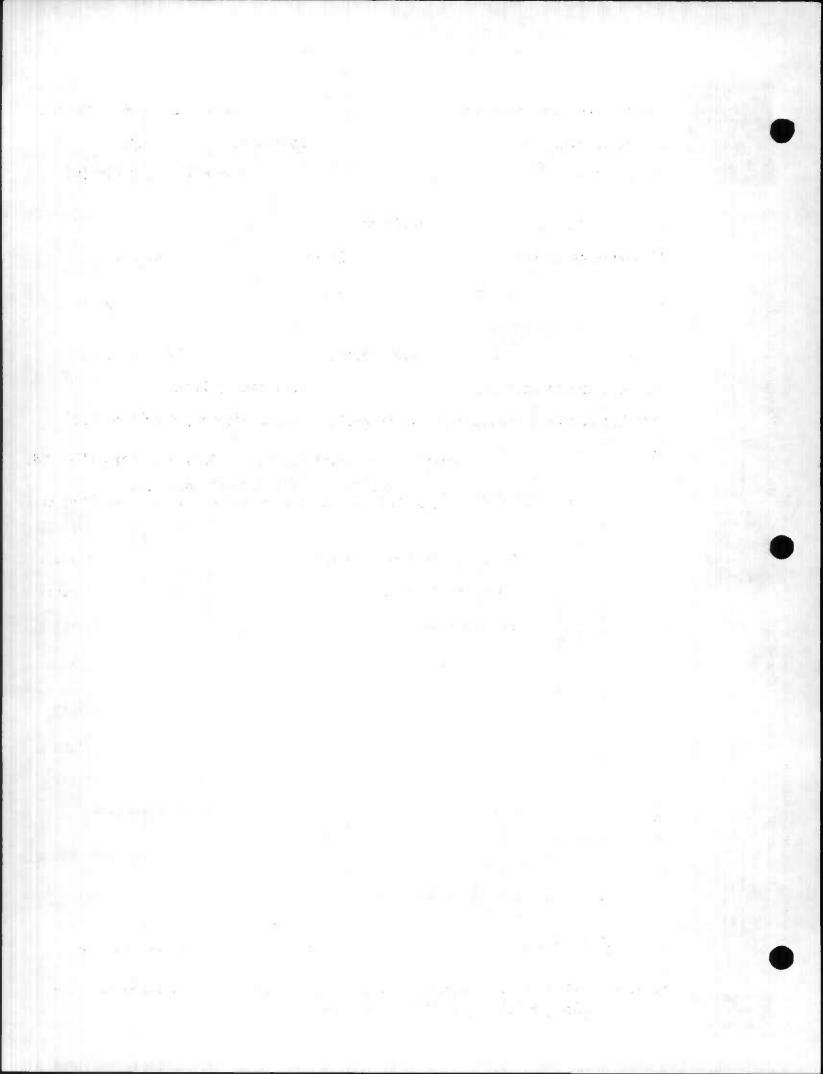
**DHMH 16 Rev 6/95** 

State Registrar

Thomas J. Enelow, M.D.,

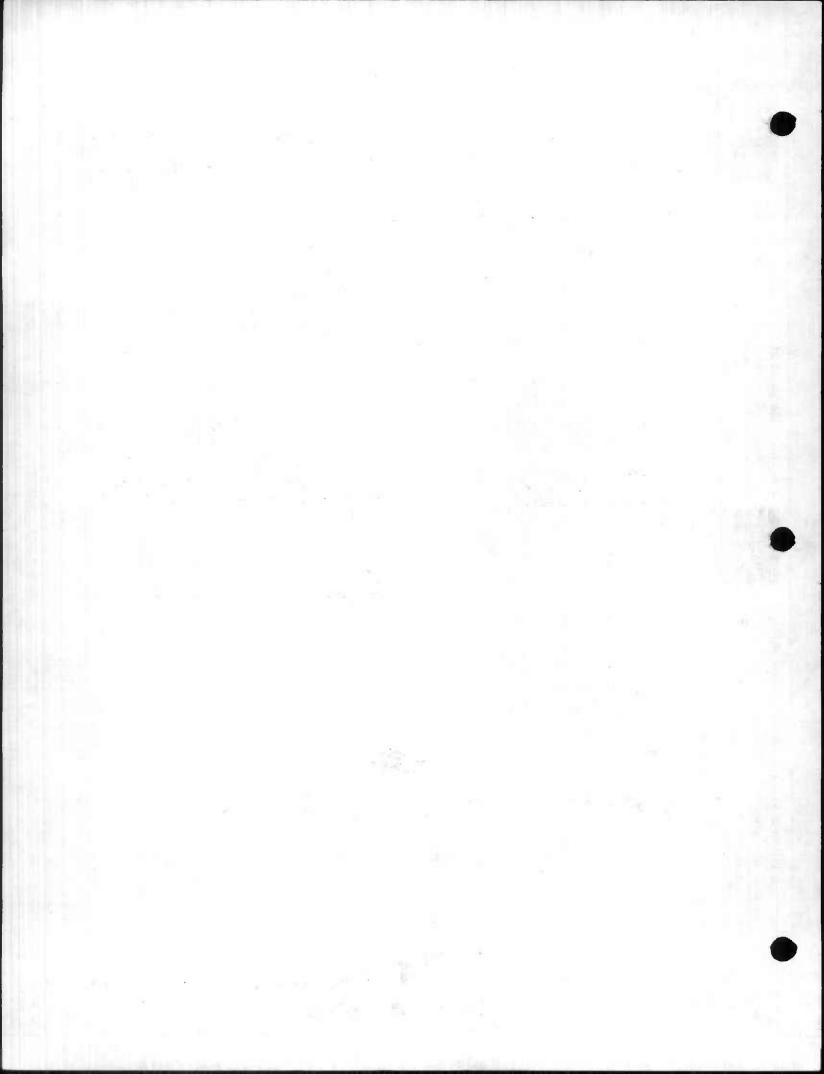
31. Date filed (Month, Day,

Name: Cobb,



#### Piease Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

KATHRYN		State of Mary				Mental Hygi	eneg 9	00	706		
CLAYCOMB	ITEMS: #23 PART I, 27 P	ER MEO G767 1-	21-99 WR	ertificate of	Death		g. No.		O Wine of Death		
Physician	Decedent's Name (First, Middle, Las  Ka	thyrn Eliz	aheth	Clavcom	h	2. Date of Death Month JANUARY	Day	Year	3. Time of Death		
/Medical Examiner	4a Facility Name (If not Institution, give		Jabe ell		4b. City, Town, or L		12, 19 4c. County		5:50P.M.		
Laminer	1311 HALLOCK DRIV	E			ODENTON		ANNE	ARUND	EL		
Funeral Director	5. Sociel Security Number 217-52-4176 6. Se		yrs. last birthda	y) If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day, NOV 8,	1948	9. Birthple Count Germa	aca (State or Foreign ny) any		
2	Usual Residence of Decedent 10a. Stete 10b. County	100	. City, Town or	Location				10	d. Inside City Limits		
Maryl 4 sho led at		Arunde1	0den						1 ☐ Yas 2 ☐ No		
vith the Ma t or 28a-f a be notified Director	10e. Street and Number	10	g. Citizen of V	Vhat Count	ry?						
desth with the Meryland rms 23e or 28e-f show Limiet be notified at neral Director	1311 Hallock D	rive		211	13		USA				
_ # # # 5	11. Marital Stetus  12. Was Decedent Ever Armed Forces?  1 Never Merried 2 Married  1 Yes 2 No If Yes, Give  3 Widowed 4 Divorced		in U,S.	3. Was Decedent of H If Yes, specify Cube  1 Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		e - America k, Whita, e	tc.		
5-00 72 hou mature deal E	15. Decedent's Edu	ucation	16a. Dec	cedent's Usuel Occup	ation	. 1	6b. Kind of Bu				
1 21215-0 ad within 72 ho ygiene. we than 'natur 4, the Medical.	(Specify only highest grad	College (1-4or 5+)	life	ve kind of work done of . DO NOT use retired memaker	during most of work d)	king	Own H	Home			
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Hygene. 7 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by f	17. Father's Neme (First, Middle, Last) Robert Vi	e (First, Middle, M Phyllis			Franz						
A sand N	19e. Informent's Neme/Reletionship (T)		19b. Me	iling Address (Street	and Number or Rui	ral Route Number,	City or Town,	State, Zip	Code)		
	Robert E. Lessard			Winters C	Chase Way			2140			
0 80 = 8	20e. Method of Disposition  1 Buriel 2 Cremetion 3 I	Removal from State	cemetery, ca	position (Neme of remetory or other place			Oc. Location -				
Saltin emit. Pa upartme mportent ny injury nose	4 □ Donetion 5 □ Other (Specify, 21. Signature of Funeral Service Lights		Metro C	rematory, 22. Name end Addres		Baltimo		ID .			
Dep Per Branch	Edwald.	orchik	Society rick Rd.	Baltimor	e, MD		Approximate				
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ecord ew requir ss been s 2 should						24a. Wes an perform	eutopsy ed?	ava con	re autopsy findings ilable prior to npletion of cause leath?		
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Division o  Division o  all or Attenting Ph  attention: After th  ed in by the funeral  Certification:	27. Menner of Death    Molturel   S   Pending   Investigation										
Hospi 14 hour Funer Tely fill	29e. Certifier 1 Certifying Phy (Check only one)										
To the within 2 To the comple	29b. Signeture and title of certifier	end menner steted.		29c. Licens	e number	29	d. Dete signe	d (Month, L	Day, Year)		
	Henry 1	Christian		0.0	C.M.E.	J	ANUARY	13,19	999		
40	30. Nama and address of person who co	ompleted cause of death	Item 23a) (Typ	e, Print)	n Street,	5					
State Registrar	31. Date filed (Month, Dey, Year)	32: Regioner's S		9. Span							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month January **Physician** 18 1999 4c. County of Death 3118 AM CRISPENS FRANK 18 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) Examiner Itospital Baltinhove

Set birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)

(Month, Day, Year) University of Maryland Itos, ocial Sacurity Number 6. Sex 7. Age (In yrs. last birthday) 5. Social Sacurity Number Birthplace (State or Foraign Country) **Funeral** M 20 F MAR 4, Maryland 218-16-1147 Usual Rasidenca of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avent, in Medical Exertinal must be notified anong. 10a. State 10b. County 10c. City. Town or Location 10d. Inaide City Limits 1 Yas 2 No Directo MD Carroll Westminster 10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? 21157 USA 203 Alymer Court Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S.
Armed Forcas?

1 ⊠Yes 2 □ No.
If Yes, Give WW II
Year or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 XMarried Specify: White 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grada completed) Balto. City Police Dept. Elementary/Secondary (0-12) Coilege (1-4or 5+) Police Officer Law Enforcement 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middla, Last) Frank Henry Crispens, Sr. Catherine Herzberger 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dolores B. Crispens/Wife 203 Alymer Court Westminster, MD 21157 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Crematory, Inc. 1/20/99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Liounsee

Columbia

Edward A. Gregorchik 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disaasa or condition resulting in death) . Sepsis 4 days Examiner Due to (or as a consequence of): Physician/Medical Examiner Acute Mueloid Leukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Dua to (or as a consequence of): signed by the a d be detached t 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yas 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending s after dec. 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined To the Hospital or Attention 24 hours after de To the Funeral Directo completely filled in by the 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 10211 Jan. 18, 1999 22 South Greene St. Balt, MD 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) University of Maryland at Baltimore Jon Von Visger

32. Registrar's Signature

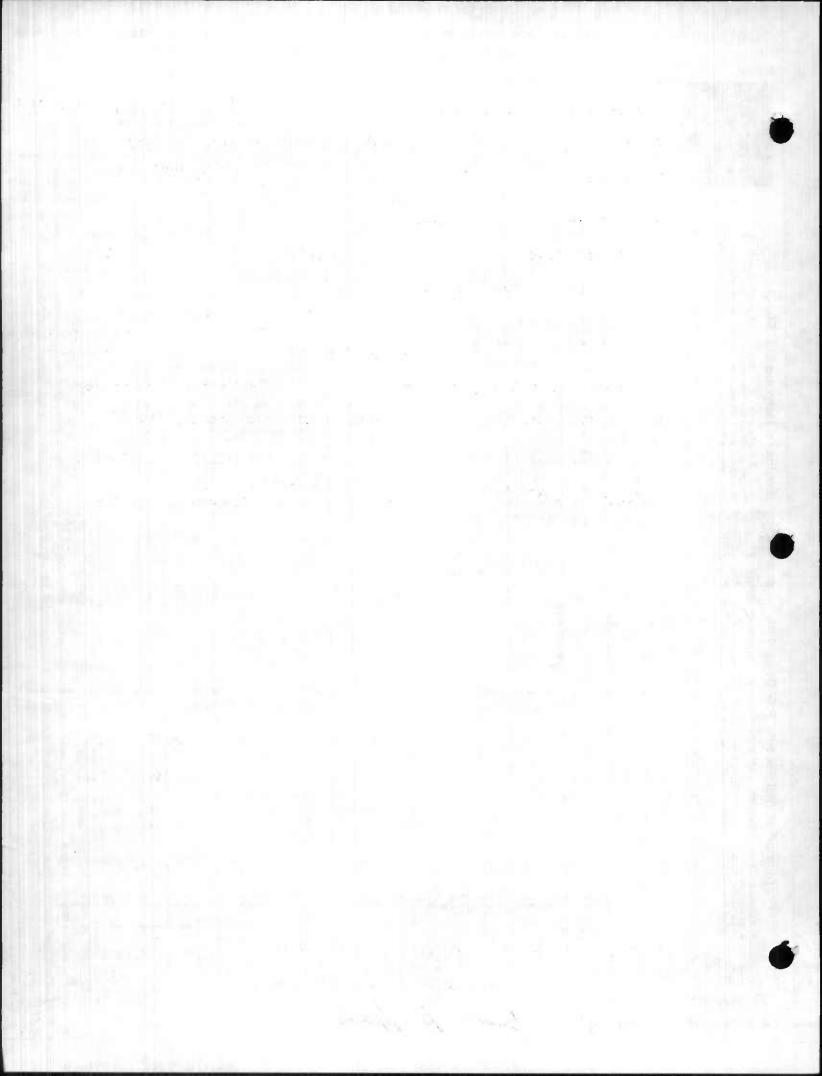
State Registrar 31. Date filed (Month, Day, Year)

JAN 19 1333

**DHMH 16 Rev 6/95** 

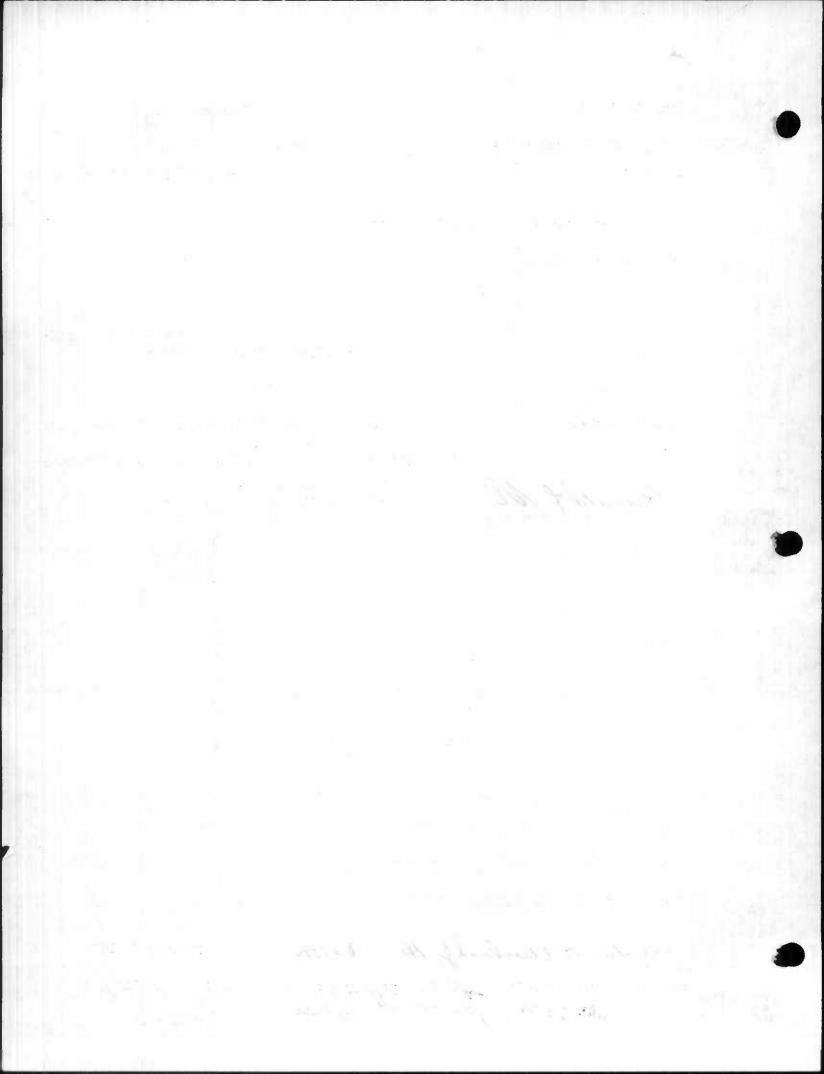
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

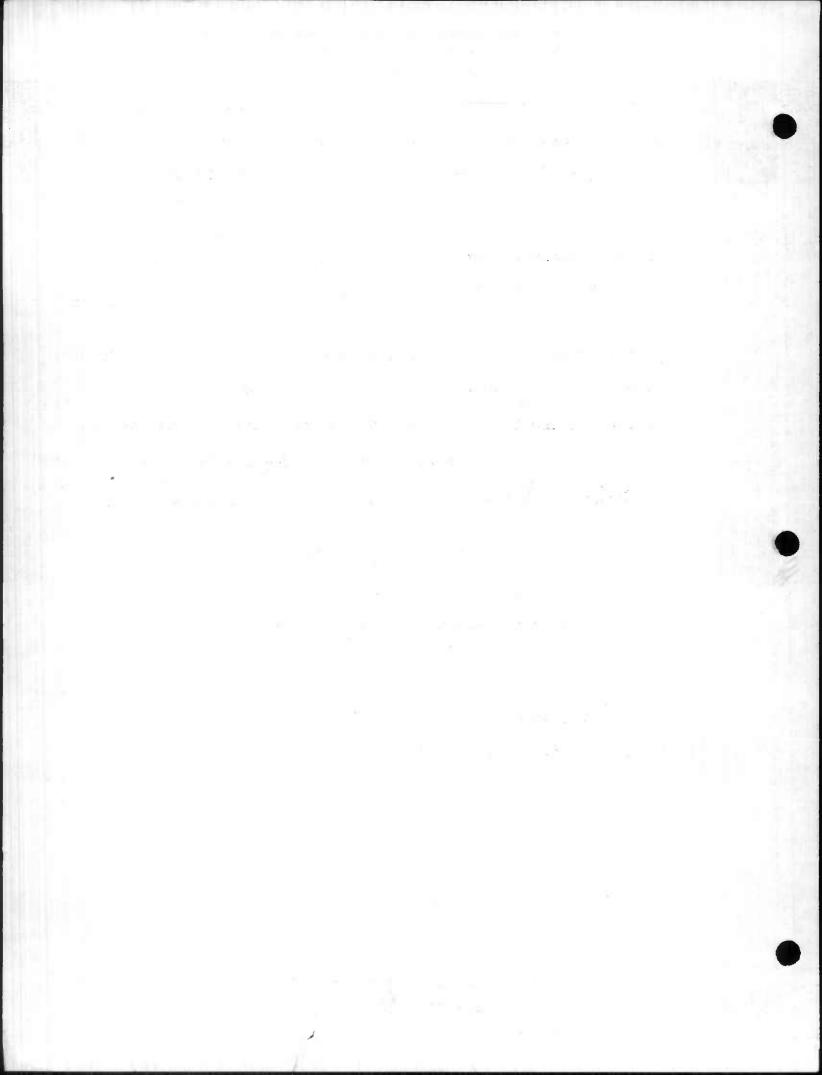
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В	Funerai		5. Sociei Security Number	6. Se	9X 7.A □M 2X2XF		. lest birthdey	) If Under Months		Hours Mi		th ey, Year)	9. Birthp	plece (State)	ete or Foreign
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	and **		10a. Stete 10b. Cou	nty		10c. C	ity, Town or L	ocation					1	Od Insid	de City Limits
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	the the north	Director	MD Mont	gome	гу	51	lver S	pring 10f. Zip				10g. Citizen of	What Caus		
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21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises must be notified at Ance.	by Funeral	1 Never Merried 2 N	1 Never Merried 2 Merried		. Wes Decedent Ever in U,S. Armed Forces?  1 ☐ Yes 2 DZNo If Yes, Give Yeer or Detes:				en, Mexican, Pue Specify:	rto Rican, etc.)	Spec	eck, White,		
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yla	tould be filed with the filed with the filed warked other that the filed water that the filed went, the filed was the filed with the filed was	9	Ralph E. Day							Mary S	mith				
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2,5	and ealth n 27		Camilla Bucze	k/Ni	ece		4933	Eastw	ood	Court,	Ellicott	City,	Mary1	and	21043
Baltimore, Maryland	of H		20e. Method of Disposition 1  ☐ Buriel 2 ☐ Cremetic	n 3∏6	Removal from State		Pieca of Disp cometery, cre	osition (Nen emetory or o	ne of ther ple	ce)	Jan.	20c. Location			
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Sall	Depart Import any in		21. Signeture of Funerel Serv	ce Licens	10			2. Name en		ss of Fecility					
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н	LAdiminet	L	Due to (or es e consequence of):												
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Box	atter	Physician/M													
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7	that ded b		Renal Failure								. 10	Yee 2 No	3 Prol	bably	4 ☐ Unknown
SD	The law requires that the death cert ite hes been signed by the attendingage 2 should be detached for use.	ed by									24e. Wes	en eutopsy	24b. We	ere eutop	sy findings
Records,	should should	Completed	Cardiac Arrythmia								perfo	rmed?	co	ellebte pr mpletion death?	of cause
Ž	The law	E O									10	Yes 21 No			o 🗆 No
Vital			25. Wes case referred to med	cal						00 Disease 6 D				Yes	2 LJ NO
	Physician: r this certifica rrai director,	To Be	exeminer? 1 ☐ Yes 2 ☒ No		Hospitel:	ent of	EB/Outpatio	nt 3 DO	Oth	05:	eeth (Check only o		has /Casaih	4	-
0	Phys er this eral di		27. Menner of Deeth 28e. Dete of Injury 28b. Time of								1	d. Describe how injury occurred			
Division of	oding I ith. : After s funer	tio	1 Neturel 5 Pending (Month, Dey Year) injury Work? 2 Accident investigation 3 Suicide 6 Could not be determined determined							k? Yes 2 □ No					
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ā	F # E C	Certification:	4   Homicide		building, et	c. (Specii	<b>Y</b> )				City or To	vn, Stete)			
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			30. Name and eddress of personal Arthur F. Woo						Corre	+ 01	y, Maryla	nd 20	832		
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	Ite	m#1	per Phy G767 1/19/99	EW	Cei	rtificate of			Reg. No.	00	/09
	Physic /Medi		1. Decedent's Nama (First, Middla, La	Ducke	11	. Duckett	•	2. Data of De Month	14 10, 19	199 /	Tima of Death  2 39 Am
j.	Exami	ner	4a. Fecility Nema (If not institution, gi		HOSPITA	,	4b. City, Town, or L. BALTIMO		th 4c. County	of Deeth	
	Funeral Director		5. Social Security Number 6.	ENERAL Sex 7. A 110 M 2 F	ge (In yrs. last birthday) Yrs.		If Under 24 Hrs.	8. Data of Bir (Month, Date 04-05		9. Birthplaca Country) MD	(Stata or Foreign
	p ,		Usuai Rasidanca of Dacedent  10a, Stata 10b, County								
	ehov	5			10c. City, Town or Lo						nside City Limits  □Was 2 □ No
	28e-1	ect	MD NA  10e. Street and Number		Baltimo	10f. Zip Coda			10g. Citizen of		-X.40
	with with	Ö		un Stree	. +	212	17			Wilat Country?	
020	d 2 should be filed within 72 hours after death with the Maryland thend Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show trainmatic event, the Medical Examination to notified at	by Funeral Director	11. Marital Stetus  1 Never Married  Marriad  3 Widowed 4 Divorced	12. Wes Deceden Armed Forces 1 1 4 7 as, Giva Yeer or Datas	t Ever In U,S. 13. \ ? I No		Hispanic Origin? (Sp pan, Maxican, Puarto	ecify Yes or No Rican, atc.)	USA 14. Rac Bie Specif	ca - Amarican Inck, Whita, atc.	
0-10	2 hor	ted	15. Decedant's E	ducation	16a. Daced	lent's Usual Occu	pation		16b. Kind of B	usiness/Industry	
d 21215-0020	2 should be filed within 7 end Mental Hygiene. Is marked other than "n aumatic event, the Med	• Completed	(Specify only highest gr Elamentary/Secondary (0-12) High Sch. Grac 17. Father's Nama (First, Middla, Las	rator  18. Mother's Nam	Amstar Company						
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Maryland	2 should and Mis mar	-	19a. informant's Name/Ralationship			g Address (Stree	t and Number or Rur				
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Balti	permit. Pege Department of Important: If any Injury or 2002.		21. Signature of Funerel Sarvice Lica				ass of Facility	alto		butus,	
c 68760,	Physician // Medicate pe exacuted be sub-considered by sician and physician and physician are the primitive properties.	Medical Examiner	Immedieta Causa (Final disaasa or condition rasulting in death)  Sequentially list conditions, if any, leading to immadiata causa. Entar Underfying Cause (Disaasa or injury that initiated events rasulting in death) Last	. Cardi Multi . Cor or	Dua to (or es a consequence of the Mylindry AK) Dua to for es a consequence of the conseq	CARDIA uence of): L-LRY	ia L Scar Arterio		95/5	Ons	et end Daath
Box	attending	an		d							
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Division o		Certification: T	27. Menner of Death  1 DNatural 5 Panding 2 Accident Invastigatio	Home 5 ☐ Rasidanca 8 ☐ Other (Specify)  28d. Describe how injury occurred							
Divi	ital or Att urs after d rel Direct										
	To the Hospital within 24 hours a To the Funerel I completely filled	Medicai	(Check only 2 Medical Example one)	niner: On the best end mannar s	of my knowledga, daath of examinetion and/or inv tated.	astigetion, in my	opinion, daath occur	and dua to tha red at the time,	date end plece,	and dua to tha	causa(s)
	To To		29b. Signatura and title of certifiar  P. Mo	ruel	•	29c. Licen	11828		29d. Deta signe	0/99	
			30. Name and addrass of person who	rorad, 1	m.1. 90	Mary	land Ge	rerai	e Hos	pitas	1
	Sta	ite	31. Dete filed (Month, Day, Year)	1000 32. Regist	gar's Signatura	4 /					

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1999 Coleman S Dunkirk 10:55 PM .Tan. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery County 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 F Hours Yrs. 057-07-1167 Director 88 Jane 28, 1910 New York Usual Residence of Decedent the Menyland 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours after death with the Menyler Department of Health and Mentel Hyglene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event, me Hearies Examiner must be northed at 9000s. 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Montgomery Bethesda 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5550 Tuckerman Lane

1. Marital Status

12. Was Decedent Ever in U.S. Armed Forces?

13. Wes 2 □ No If Yes, Give 20852 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Stockbroker Stock/Financial 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Sarah Kahn William Dunkirk 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

12617 Lamp Post Lane Potomac, MD Date 20c. Le MD 20854 20c. Location - City or Town, State David Grover Cousin 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON Va. Crematory 4 Donation 5 Other (Specify) No. 21. Signature of Funeral Service Licer 22. Name and Address of Facility Ives-Pearson Funeral Home 2847 Wilson Blvd. Arlington, VA 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, auch as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Se The law requires that the death certificate be executed physician end s the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 80 980 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24e. Wes an eutopsy performed' page 2 : 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 28 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 1. Natural 5 ☐ Pending efter death. Director: Aft 1 Yes 2 No investigation 2 Accident the Funeral Director of the Fu 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and manner es stated. Medical

Hospital

completely

within 2 To the

(Check only one)

29b. Signature and title of celtific

31. Date filed (Month, Day, Year)

> hop

State Registrar

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w Alan

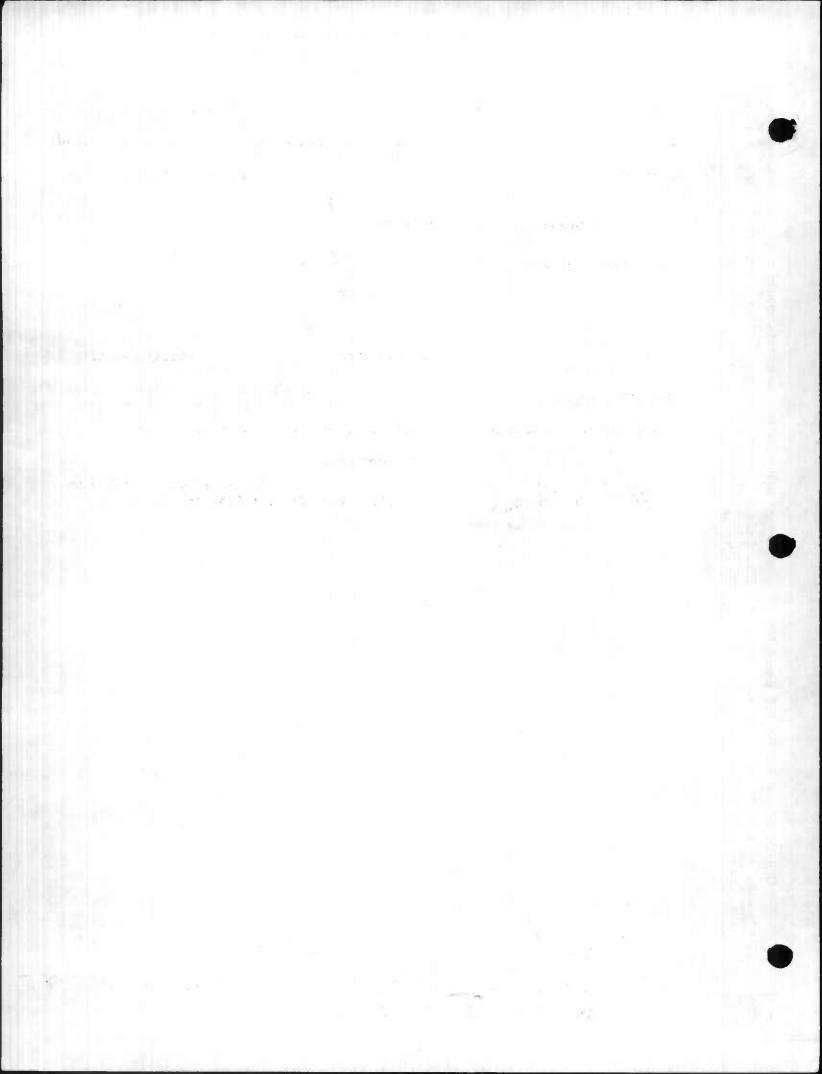
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) end menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

10215 Fernwood Pd, Bethosda MD 208/7

32. Regi 's Signature JAN 191999



Box 68760, Division of Vital Records, P.O.

The law requires that the death certificata be executed burial-transit ettending physicien for usa as the buna been signed by the should be detached has certificata or Attending Physician: director, this funeral After daath. Hospital

Physician

/Medical

**Examiner** 

**Funeral** 

**Director** 

r than "naturel", or items 23a or 28s-f show the Medical Expenies must be notified at

filed within 72 hours after of Hygiena.

marked other

permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other treumatic event, phose.

**Physician** 

/Medical

Examiner

Physician/Medical

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Certification: To

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Baltimore, Maryland 21215-0020

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n 24 hours after death.

Funerel Director: A pletely filled in by the fu completely within 2

Registrar

29b. Signatura and title of certifian

29c. Licansa number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Dala signed (Month, Day, Year) January 13, 1999

Johns Hopkins at MerrittPark, 1792 MerrittBoulevard, Balto MD 30. Nama and addrass of parson who completed causa of daath (Itam 23a) (Type, Print) A. Newill MD

28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Spacify)

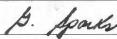
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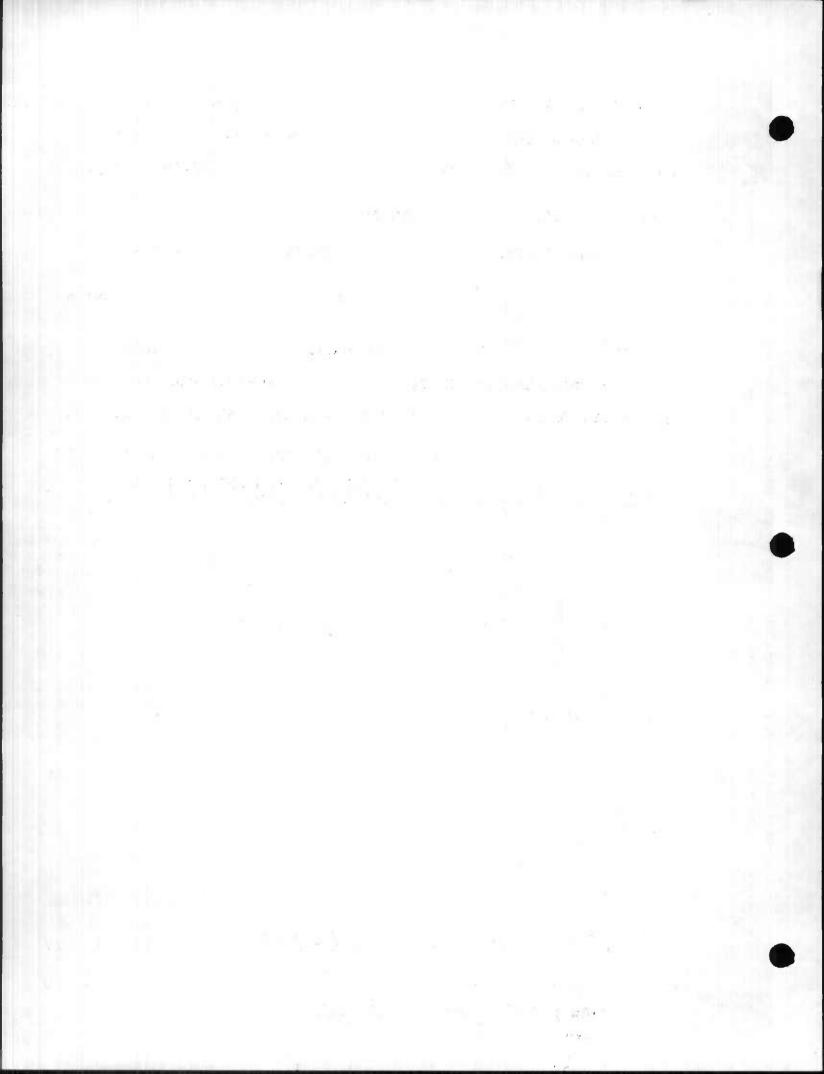
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(Check only one)

29a. Cartifiar

32. Registrar's Signatura JAN 191999





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15. Decedent's Education (Specify on highest grade completed)   16a. Decedent's Usual Occupation (Give the drug most of working life. DO NOT use relified)   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   19. Mailing Address (Sireet and Number or Rural Route Number. City or Town, Stee, Zip Code)   19. Mailing Address (Sireet and Number or Rural Route Number. City or Town, Stee, Zip Code)   19. Mailing Address (Sireet and Number or Rural Route Number. City or Town, Stee, Zip Code)   19. Mailing Address (Sireet and Number or Rural Route Number. City or Town, Stee, Zip Code)   19. Mailing Address (Sireet and Number or Rural Route Number. City or Town, Stee, Zip Code)   19. Mailing Address (Sireet and Number or Rural Route Number. City or Town, Stee, Zip Code)   19. Mailing Address (Sireet and Number or Rural Route Number. City or Town, Stee, Zip Code)   19. Mailing Address (Sireet and Number or Rural Route Number. City or Town, Stee, Zip Code)   19. Mailing Address (Sireet and Number or Rural Route Number. City or Town, Stee, Zip Code)   19. Mailing Address (Sireet and Number or Rural Route Number. City or Town, Stee, Zip Code)   19. Mailing Address (Sireet and Number or Rural Route Number. City or Town, Stee, Zip Code)   19. Mailing Address (Sireet and Number or Rural Route Number. City or Town, Stee, Zip Code)   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Racily   19. Mailing Address of Ra	al Direc	10e. Street and Number  5511 Deer Park Road  10f. Zip Code 21136  10g. Citizen of 1											
Four   Four	by Funer	1 ☐ Never Married 2 ☐ Ma	rried 1 Yes	Forces? s 2 No Give				pecify Yes or No- o Rican, etc.)	Bla	ck, White, etc.	ndian,		
19e. Informant's Marier Let Galliber:  19e. Informant's Marier Pleatinship (Type, Print)  Orville Joy = Son  20e. Method of Disposition 1	npieted	(Specify only high	est grede complete		(Give kind life. DO	of work done NOT use retin	rk done during most of working se retired)						
196. Informant's Name/Reletionship (Type, Print) Orville Joy = Son  20a. Method of Disposition 1	Co	17 Fether's Name /First Middle	( ant)		Но	usewif		no /Firet Middle A			_		
23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line.    Approximate   Approximat	o Be								Waldell Sullial	nej			
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Part II. Other significant conditions contributing to death but not resulting in fhe underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of the ca	6 -	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last											
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Pospital: 1 Inpetient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify)  27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury Work?  28d. Describe how injury occurred 1 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred	E CO							1 🗆 Y	es 2000	1 □ Y€	s 20 No		
27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury Work? 28d. Describe how Injury occurred Work?	Be Be	25. Wes case referred to medic examiner?						ath (Check only or	ne)				
1 Nature   2   Accident   3   Suicide   4   Homloide   4   Homlo	7.		11			3LI DOA	AN Nursing I	Y					
building, etc. (Specify)  29a. Certifier  29a. Certifier  (Check only 2011 Medical Examiner: On the basis of examination and/or investigation in my obtains death occurred at the time, date and place, and due to the cause(s) and manner as stated.	oy me rune ification	Naturel 5 Pend inves 3 Suicide 6 Could	tigation I not be	ce of Injury - At h	Injury nome, farm, street,	M 1[	ork? ⊒Yes 2□No	28f. Location (Street and Number or Rural Route Number,					
(Check only 21) Medical Examiner: On the basis of examination and/or investigation, in my online, death occurred at the time, date and piece, and due to the car	al Cert	29a. Certifier 1 Certify				curred at the	time, date and place			anner as state	d.		
one) 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, deterand place, and due to the care	edic				ation and/or invest	igation, in my	opinion, death occu	urred at the time, d	lete and piace,	and due to the	cause(s)		
29b. Signature and fittle of our file our file of our file of our file our file of our file of our file of our file our file of our file our file our file our file our file of our file our	<b>▼</b>	29b. Signature end fitte of curtil	9)			29c. Licer	nse number	2	9d. Date sign	ed (Month, Day	, Year)		
M.D. DSUSSI 11899		A	0	- m	10.	150	1557		1/18	99			
30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print)		1	a who completed on	use of death (Ite	m 23a) (Type, Prin	t)			1.				

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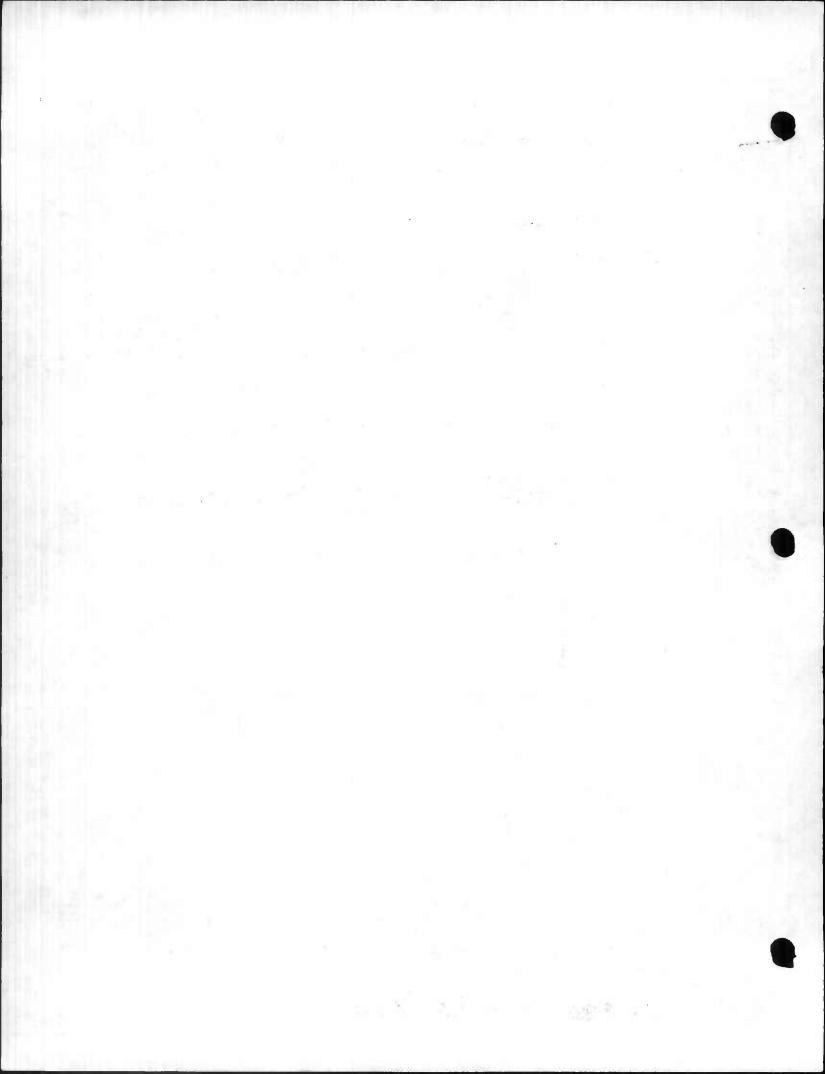
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State of Maryland / Department of Health and Mental Hygiene \( \text{\text{\$Q\$}} \)

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Physician January 6, 1999 1:46 PM Frederick Dreyer /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard Howard County General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 20, 1901 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Days Hours 1X M 2□ F Yrs. 97 Germany Director 178-03-6245 Usual Residence of Decedent r 28a-f show a notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Anne Arundel Maryland Pasadena 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code F Barria 23a or 21122 United States 8395 Quailwood Lane Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 11. Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 natural, or 1 Yes 2X No Specify: Specify: White à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry flied within 72 U. S. Army Corps. Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Engineer Draftsman of Engineers permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oths any Injury or other traumatic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 80 2 Heinrich Drever unknown unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Frederick D. Dreyer / Son Same as item 10e. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremetion 3 ☐ Removal from State 1/9/99 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Timothy Harman Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Pert1. Enter the escrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Acute Myocardial Infarction Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): signed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4€ Unknown Records, à The law requires 24a. Wes en autopsy performed? 24b. Were eutopsy findings aveilable prior to Completed completion of cause of deeth? page 2 1 ☐ Yes 2 1 No 1 ☐ Yes 2 No certificate Division of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel 5 Pending death. n 24 hours after death. The Funeral Director: A pletaly filled in by the fi 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29e. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only 29b. Signatu 29c. License number 29d. Date signed (Month, Dey, Year) and title of certifier Msim, MI) D35217 January 18 , 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Jackson, M.D. 11055 Little Patuxent Parkway Columbia, MD 21044 32. Registrar's Signa State Registrar

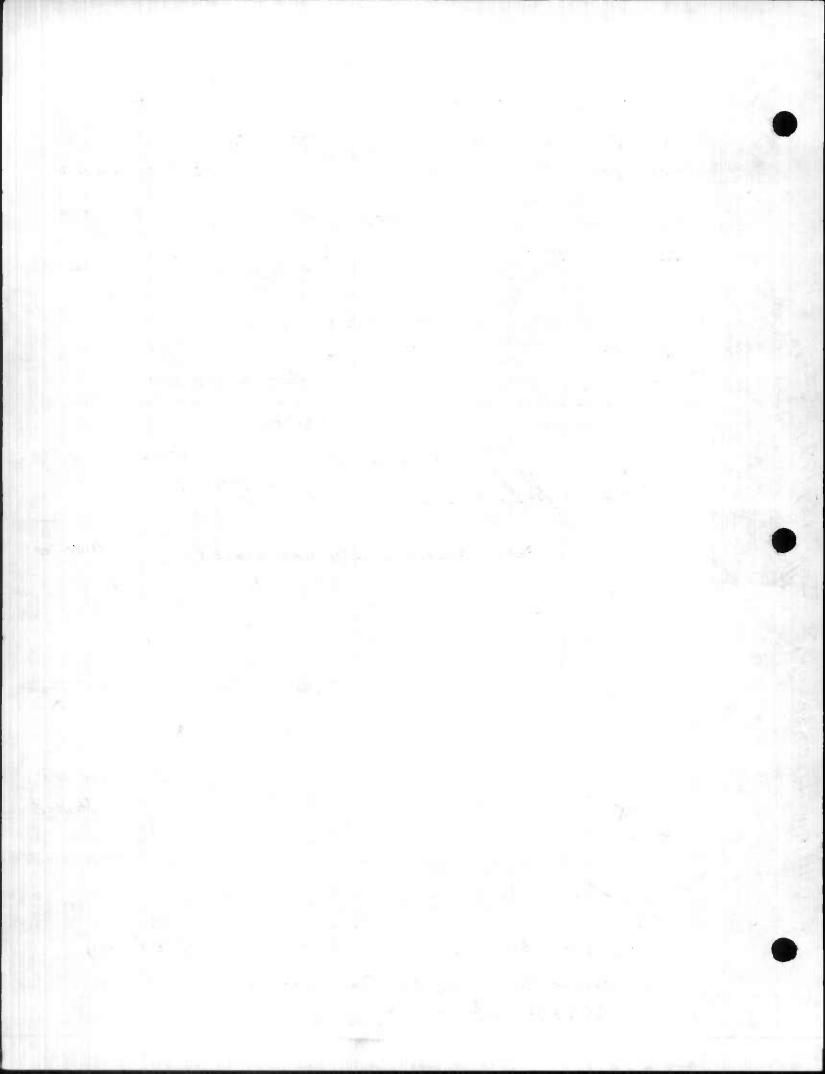


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State of Maryland / Department of Health and Mental Hygiene 9 0 7 1 4

					Certificate	e of	Death	R	leg. No.	) 0	0/19
N	_	. Decedent's Nama (First, Middle, La:	st)					2. Data of Dea Month	th Day	Year	3. Tima of Death
hysician /Medical	_	WILLJAM ANDF	EW DICKE	RSON J	R			JAN		1999	5:50 rm
aminer	4	a Facility Name (If not institution, give	e street and number)				4b. City, Town, or I	Location of Death	4c. Coun	ty of Death	
		JOSEPH RICHEY H	OSPICE INC				BALTIMORE:		N	/A	
eral	5	. Social Security Number 6. S	ex 7. Age (	In yrs. last birt	Months			8. Data of Birth (Month, Day	Year)	9. Birth	placa (State or Foreign
ctor	-	226-28-9989	Mw 501	70	Yrs.			OCT 2	4 1928		RGINIA
2	-	Jsual Residence of Decedent  Oa. Stata 10b. County	11	0c. City, Town	or Location					1.	10d. Inside City Limits
5	1										XXYas 2□No
Director		MARYLAND N/A		E	W.L.T.IMORI		LTY				
		0e. Street and Number			10f. Zip				l0g. Citizen o		ntry?
Funeral		2524 KEYWORTH AVE		1 11 5	Land		1215		U.S.		
5	1 1	1. Marital Status	12. Was Decedent Eve Armed Forces?	er in U,S.	13. Was Deced	lent of I tify Cub	Hispanic Origin? (S van, Mexican, Puert	pecify Yas or No- o Rican, atc.)	14. Ha	ace - Americ ack, White,	
by F		1 Never Married 2 Married 3 Widowed 4 Divorced	XXYes 2 No If Yas, Giva Year or Dates: 4.5	= / 16	1 Yes 3	XXNo	Specify:		Spec	ity: D7	7. OT-
					D	10			401-401-4		ACK
Completed		15. Decedent's Ed (Specify only highest gra		168.	Decedent's Usua (Give kind of wor life. DO NOT us	rk done	during most of wor	king	16b. Kind of	Businass/in	dustry
E		Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)	Т	ATHE OP				BBC	TNDII	STRIES
ပိ	1	7. Father's Name (First, Middle, Last)		1 1	MIIII (4)	Liter.		na (First, Middle,			DITCLE
Be	5	WILLIAM A. DICKEF	SON. SR					WAFREN D			
2	-	19a. Informant's Name/Relationship		400	Mailing Address	/C+					o Codel
			,, ,				t and Number or Ru				
	2	Sarah E. Dickers On. Method of Disposition	son/Wite:		Disposition (Nan		n Avenue,		re, Mai		
	1	Burial 2 Cremation 3	Removal from Stata	cemeter	y, cremetory or o	ther pla					
		4 Donation 5 Other (Specif)	11 0	GARRI	ISON FOR			1-22-99	OWINGS	MILL	S, MARYLAND
SOO.	2	1. Signature of Funeral Service Licen	100		22. Nama an	d Addra Γ.ΤΔΝ	A C BROWN	COMMENT	MIT VE	ERAT.	HOME PA
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Physician/	P	art II. Other significant conditions of	ontributing to death but r	not rasulting in	the underlying ca	ausa gi	ven in Part I.	23b. Did to	obacco use d	ontribute t	o the cause of death?
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Completed by	-							perior		00	ompletion of cause death?
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Ü	2	5. Was case refarred to medicat					26 Pleas of Day	ath (Check only or			_ 100 240110
o Be		axaminer?	Hospital:	2 ER/Out	tpatient 3 DO	Ot	hor	loma 5 ☐ Rasid		ther /Coes	HOSPICK
To the Hospital or Attending Physician: Tha I within 24 hours after death. To the Funeral Director: After this cartificate hy completely filled in by the funeral director, page Medical Certification: To Be Com	2	7. Manger of Death	28a. Date of Injury (Month, Day Y			28d. Describe h		1-1-1-1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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fica		3 Suicide 6 Could not be		- At homa, fai	rm, street, factory					nber or Run	al Route Number,
Medicai Certifi		4 Homicide	building, atc. (	Specify)				City or Tow			
O	2	9a. Certifier 1FT Certifying Phy	reician: To the best of n	ny knowledce	death occurred	at the ti	ma date and place	and due to the o	ausa(s) and r	nenner as 4	stated
edicai	1		iner: On the basis of ax	amination and	Vor Investigation,	in my	opinion, death occu	rred at the time, d	lata and place	, and dua t	o tha cause(s)
×		9b. Signature and title of certifier	A		290	. Licen:	se number	- 2	29d. Data sign	ned (Month.	Day, Year)
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egistrar		JAN 19	1999	M. C.	10. 1	na	Kal				

William Dickerson, Sr.



Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 1-19-99 rja State of Maryland / Department of Health and Mental Hygiene 99 0715 Item 31 Per DVR Film G76Z.

	ician dical	1. Decedent's Nam  John V	e (First, Middle, L Ternon		Sr.						2. Data of Dec Month Januar	Day	L <b>999</b>	3. Tima of Death 7:25am		
	niner	4 P										on of Death  4c. County of Death  Baltimore				
Funer Directi		5. Social Security N 235-42-28		Sex 125 M 2□ F	7. Age (In yrs 70	. last birthda Yrs.	y) If Unde Months	Days			8. Date of Birth (Month, Day, Year) 7-22-1928		9. Birt	hplace (State or Foreign unity) Virginia		
the Maryland 28a-f show	tor	Usual Residence o	The same of the sa								10d. Inside City L 1 ☐ Yes 2 】					
death with the Marylend ms 23a or 28a-f show	ā	10e. Street and Nur 2312 Ho1		d		10f. Zlj	Code	21237				D. Citizen of What Country?				
or its	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decadent Ever in U.S. Armed Forces?  1 X Yes 2 No 1 Yes, Give 1 4 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1					It Yes, specify Cuban, Maxican, Puerio Rican, etc.)  Black, White, etc.  1 Yes, 2 X No. Specify: White.							e, etc.		
2 5 g	leted	(Spec	15. Decedent's E cify only highest gi	ducation	ucation		16a. Decedent's Usual Oc		al Occupation rk done during most of work se retired)		king 16b. Klr		Ind of Business/Industry			
d within giene.	Completed	Elementary/Seco		College (	1-4or 5+)		Bus Driver				MTA					
/land 2 uld be filed Aentel Hygi rked other	To Be C	17. Father's Name (First, Middle, Last)  Everett W. Dodds					18. Mother's Name (First, Middle, Maiden Surname)  Mary Armstrong									
ond 2 short self head A 27 is man		19a. Informant's No Rosa Dode		(Type, Print) <b>S</b> ]	pouse 19b. Mailing Address (Street and Number o 2312 Holyoak Rd., Ba									,,		

20b. Placa of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

xees 263 S. Conkling St., Baltimore, Maryland 21224 23a. Part1. Enter the disaase, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Daath Renal Failure Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence ot): Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension þ 24b. Were autopsy findings available prior to completion of cause ot death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2

Other: 4 Nursing Home 5 Residence 6 Domer (Specify) Huspice 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) edicai Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 DNatural 5 Pending 1 □ Yes 2 □ No 2 Accident Investigation 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tive of ca-29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D43725

Eutan St # 308 Baltimore MD21201

20c. Location - City or Town, State

1/12/99 Baltimore, Maryland

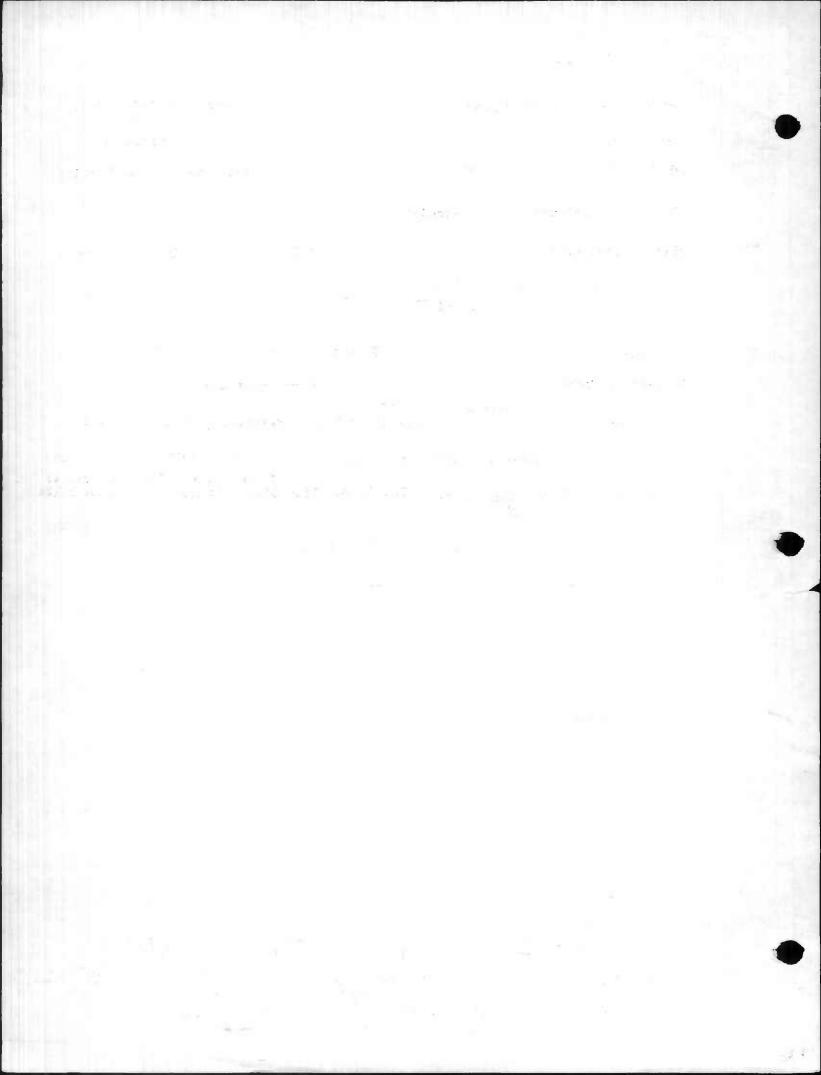
22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Hm.

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 7:06 AM Marguerite January 1999 Daniels 14 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Agt. City, Town, ...

If Under 24 Hrs. 8. Date of Birth
Hours Min. Month, Day, Y Examiner ver 9 Birthplace (Stata or Foreign Opuntry) 7. Age (In yrs. last birthbay) 83 Yrs. 6. Sex 5. Social Security Number **Funeral** 1 M 2 F Months Days 207-12-252' Usual Residence of Decedent Director rainia permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a.d. reny injury or other traumatic event, the Maryland once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo mor Maryland 10f. Zip Code 10g. Citizen of What Counfry? 10e. Street and Number de d Funeral 12. Was Decedant Evar in U/S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. 13. 11. Marital Status Black, White, etc. 1 Never Marriad 2 Married 1 Yes 2 No Specify: þ 3 Nidowed 4 Divorced American ttro-MARGUri Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Educetion (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) an O 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be unge 9 W 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zin Code) 19e. Informant's Name/Relationship (Type, Print) (autohter Balto. Md. 21210 100 uai 20b. Place of Disposition (Nam cemetery, cremetory or of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) reenmount 22. Name and Address of Facility of Funeral Service Licens Joseph L. Russ Funer 2222 W. North Ave. Ba the death. Do not enter the mode of dylng, such as cerdiac or respiretory arrest, the failure. List only one ceuse on each line. Hom era 21216 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final accident Cerebro-vasculal diseasa or condition rasulting in death) Examiner Due to (or as e consequence of): Physician/Medical Examiner 2 years + athericlessis cerebro-vascular Wids spread attending physician and for use as the burial-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated avents rasulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed b þ 24b. Were eutopsy findings available prior to completion of ceuse of deeth? Completed 24e. Was an autopsy performed? Deen certificate has b The 2 No 1 Yes 1 Yes 2 No or Attending Physician: director. Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 20 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 DOA slut Director: After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Numbar, City or Town, State) 4 - Homicida 24 hours after Funeral Dire letely filled in b Hospitai 29a. Certifier 126 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner es stated. edical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. (Check only one) within 2

29c. License number

1731052

29d. Date signed (Month, Day, Year)

January

3333 N. Calvert St, 4325, Baltimore MD 21218

15

State Registrar 29b. Signature and title of certifier

30. Neme end address of person

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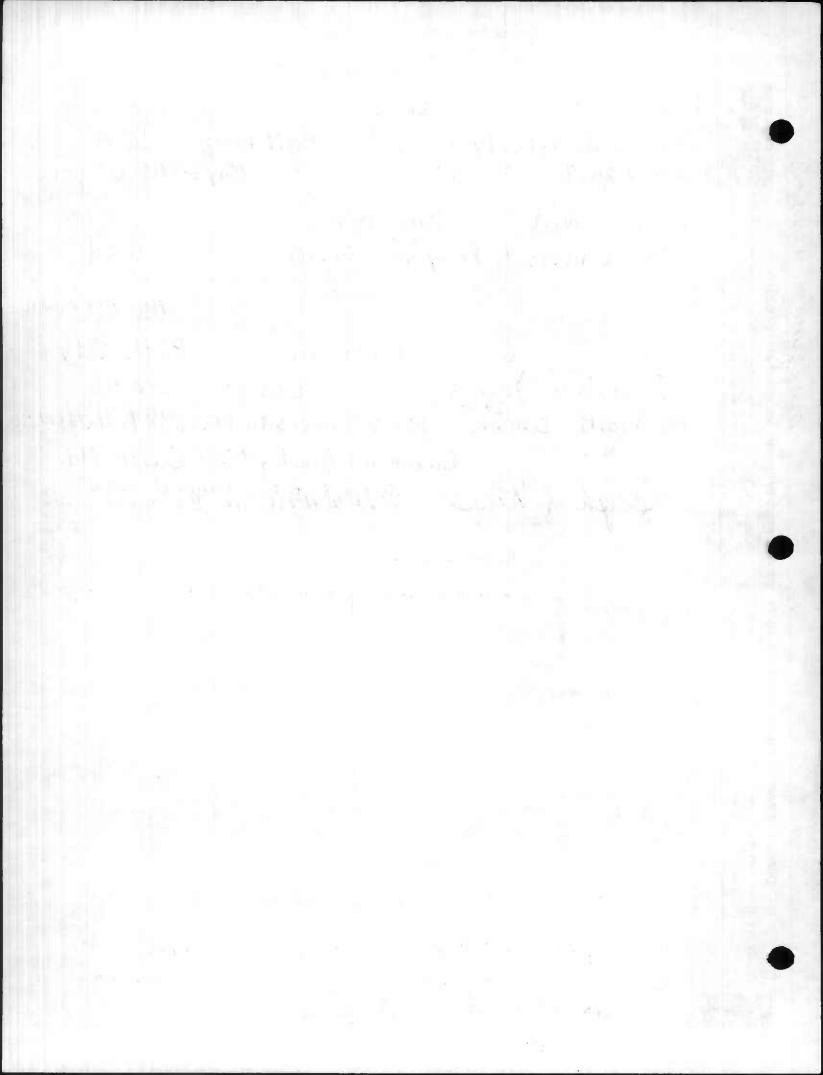
31. Date filed (Month, Day, Year) JAN 1 9 1999

who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

Rosenthal, m.D.

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day January 15 177 151999 09:51 A ronico 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, give street and number) Dinai Hospital Baltimore If Under 24 Hrs. 8, Date of N/A If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birthplace (State or Foreign /Country) Months Deys 212-56-6808 Usual Residence of Decedent Hours 10 M 20 F arv 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Maryland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 481 eight dold 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Wes Decedent Ever in U.S. 11. Maritel Status Armed Forces Black White etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Appecity: 3 ☐ Widowed 4 ☐ Divorced Hmericar Yeer or Dates: 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementagy/Secondary (0-12) College (1-4or 5+) 01 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) omith 19a. Informant's Name/Relationship (Type, Print) (SIS 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Çode) ter) re a, reciou 20b. Place of Disposition (Name of 20e. Method of Disposition Date/ 20c. Location - City or Town, Stete cremetory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mem. Gardens 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Fecility Rus Joseph ome 2/2/6 Tue. Bai W. North Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart utilure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) Sepsis Due to (or as a consequence of): Multiple system organ failure Due to (or es a consequence of): Cirrhusis Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 2D No 1 Yes 1 Yas 2 No

**Physician** /Medical Examiner

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Hospital or Attending Physician:

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Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

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Examiner

**Funeral** 

Director

7 is marked other than "natural", or flams 23s or 28s-f show traumstic event, the Medical Examiner must be notified at

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Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Wes case referred to medical examiner?

1 Yes 2 No 27. Menner of Death 1 Naturet 5 Pending

2 Accident 3 Suicide 4 Homicide

Investigation 6 Could not be determined

28a. Date of tnjury (Month, Dey Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes

1 Ccritifying Physician: To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) and manner as stated.

28e. Ptaca of Injury - At home, farm, street, factory, office bullding, etc. (Specify)

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

(Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and menner stated. 29b. Signature and title of certifier

29a, Certifier

29c. License number

January 15, 1999

29d. Dete signed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Bullock 31. Date filed (Month, Day, Year) 9 1999

2401 West

Belvedere Avenue Baltimore MD 21215

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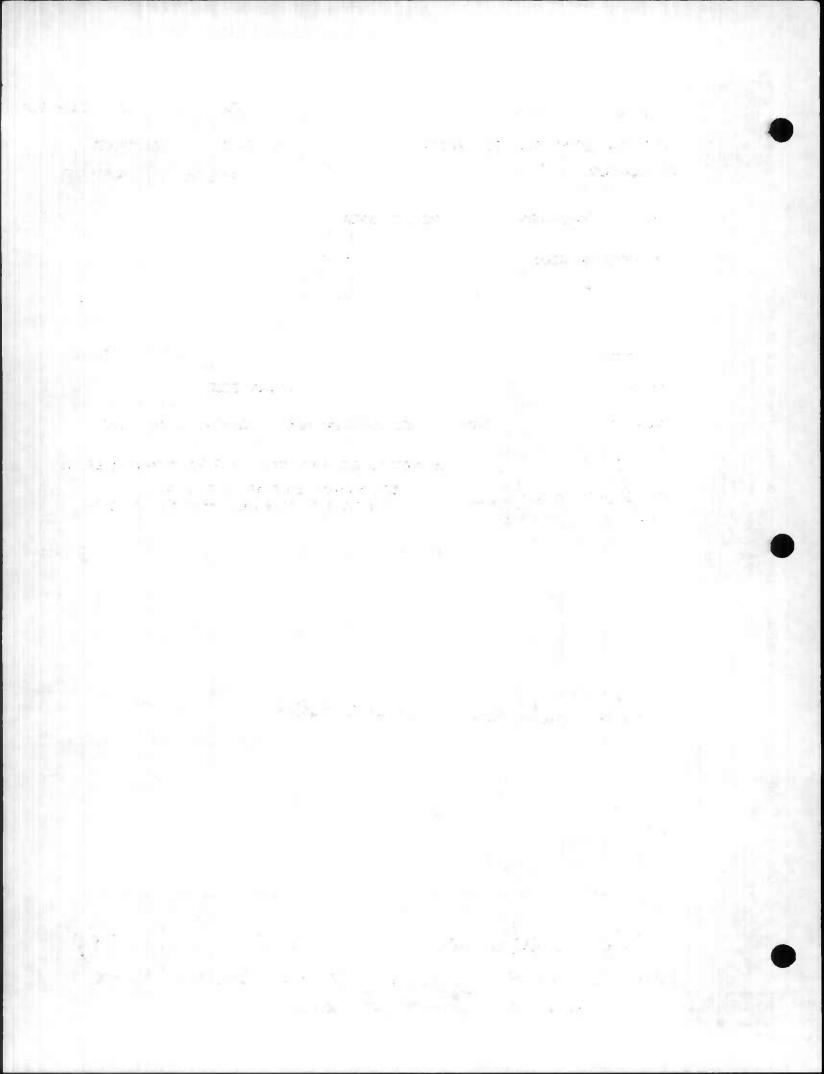
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dev Year **Physician** 12 1999 JAN. 9:04 P.M. PHILIP L. DRITT /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner FRANKLIN SOUARE HOSPITAL CENTER ROSEDALE BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex 8. Dete of Birth (Month, Day, Year) **Funeral** Min. 1♥M 2□F Days Months Hours 216-38-2899 58 Director MARYLAND 6/23/40 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits rthan "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Directo BALTIMORE MIDDLE RIVER 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? with Funeral 201 ANTIETAM ROAD death 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece -12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus Black, White, etc. Yes 2 No 1 Never Married 2 Merried Maryland 21215-0020 1 Yes ♥ No Specify: Specify: 20 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) PROCESS CONTROLLER 8th Grade LEVER BROTHERS other 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hants! Hitem 27 is marked oth Be DAVID DRITT MILDRED RICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Reletionship (Type, Print) JEAN DRITT WIFE 201 ANTIETAM ROAD BALTIMORE, MD 21221 other altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 1 Donation 5 ☐ Other (Specify) 0 permit. Page Department of Important: If any Injury or 5 ☐ Other (Specify) DULANEY VALLEY MEM. GAR. 1/16/99 COCKEYSVILLE, MD uneral Service Licansee 21. Signatule of 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Approximete
Interval Between
Onset and Death 8521 LOCH\_RAVEN\_BLVD.\_\_TOWSON, MD enter the mode of dying, such as cardiac or respiratory arrest, nt. Enter the disease, or complications that caused the death. Do not ock, or heert failure. List only one cause on each line. **Physician** /Medical immediate Ceuse (Finel 6 mm disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): 950 23b. Did tobacco use contribute to the cause of death? Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part,i. ate has been signed by the page 2 should be detach 1 Yss 2 No 3 Probably 4 Unknown Records. à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy Completed performed? 1 TYAS 2 000 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician: director. Be 25. Was case referred to medical 28. Piece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2☐ No 2 1 Yes 1 ☐ inpatient 2 DER/Outpatient 3 ☐ DOA this funerai 27. Menner of Death 28a. Dete of injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Netural 5 Pending investigation s after death. 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piaca of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piaca, and due to the cause(s) end manner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. To the Hosp within 24 hou To the Fune completely fil 29a. Certifier edicai 29d. Date signed (Month, Day, Year) 29c. License number 295. Signature and title of certifier the and eddress of person who completed cause of death (Item 23a) (Type, Print) N. OT. 60 - Engrand duis 1 9 1999 Registrary Signature 31. Date filed (Month, Day, Year)

State Registrar

JAN



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month :00 AM 1)REGA -LORENCE JAN. 15 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death MARTINS BALTIMORE NURSING HOME CATONSVILLE If Under 1 Year If Under 24 Hrs. 8. Deta of Birth
Months Days Hours Min. (Month, Day, Year)
SERT, 12,1914 Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 1 M 2 D Yrs 212-07-9068 MD Usual Rasidance of Decedent 10a State 10h Count 10c. City, Town or Location 10d Inside City Limits 1 Yas 2 No BALTIMORE CATOUSVIlle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 MAIDEN CHOICE LANE U.S.A 601 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-II Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 Naver Married 2 Married 1 Yas 2 NHO 1 Yas 2 No Specify: Specify: WhITE 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elamantary/Secondary (0-12) Collega (1-4or 5+) HOUSEWIFE HOME NIA 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) JOSEPHINE KNASINK ZIOMEK LAWRENCE 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 601 MAIDEN Choice LN. BALTO MD 21328 DREGA (DAVEHTER) MRS JOAN 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata CEMETERY 1/18/99 4 ☐ Donation 5 ☐ Othar (Specify) BALTIMORE, MD STANISLAUS 22. Nama and Addrass of Facility Her Funeral Home CHTD. 21. Signature of Funeral Service Licensea Miller 7527 HarFoRD- FD. BACTE MD 2-12-34 23a. Part1. Ental the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final RIGHT PNEUMONIA diseasa or condition rasulting in daath) DAYS. Dua to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exects. Dua to (or as a consequence of): that initiated avants resulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS WITH neuropalty ISCHEMIC AND CONGESTIVE CARDIO 24b. Wara autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? MYOPATHY HCUT E CHROMC RENAL FAILURE. AND 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima ol 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 3 Suicida 6 Could not be dataminad 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 - Homicida

physician and s the buriel-trans certificate be execu Division of Vital Records, P.O. Box 68760 has or Attending effer death.

Examiner Physician/Medical as 980 à 2 Completed Be 10 Certification:

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumstic event, the Ma

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with the Maryland

death

filed withIn 72 hours efter

Baltimore, Maryland 21215-0020

To the Hospital within 24 hours of the Funeral completely filled

edical

29b. Signature and little of certifier

29c. Licansa number D18362

150 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year) Jan. 15, 1999.

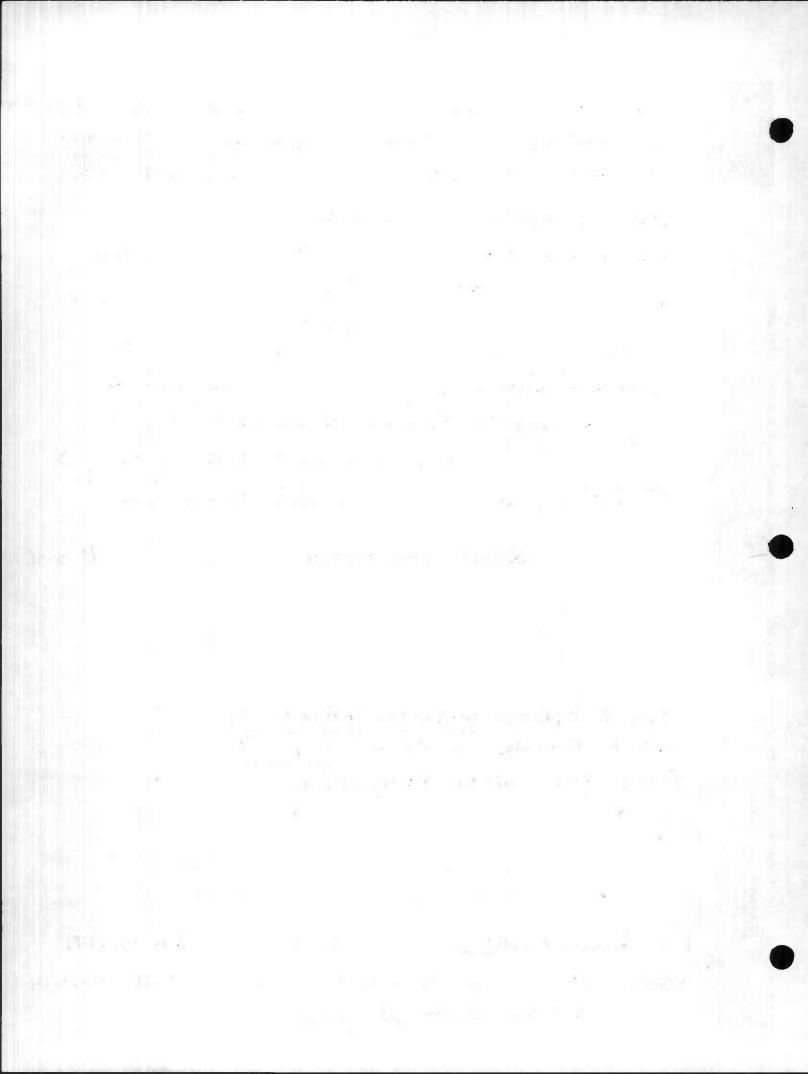
30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

AVE, SUITE 308; BALTO, MD 2/229 KOMAL K. DANG M.D., 3455, WILKENS 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

State Registrar

29a. Cartifiar (Check only

JAN 1 9 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( DAPHANTE Certificate of Death DAWKINS 3. Tima of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death Daphne V. Dawkins Month Year **Physician** JANUARY 10,1999 11:35A.M. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5960 TURNABOUT LANE HOWARD COLUMBIA If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) June 3, 1934 Birthplaca (Stata or Foraign Country)
 Jamica 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 131-44-6943 1 M 20 F 64 Director Usual Rasidence of Decedent 10d. Insida City Limits 10c. City. Town or Location 10a Stata 10b. County than "natural", or items 23s or 28s-f show the Medical Exempler must be notified at Columbia 1 Yas 2 No Howard Maryland Director the th 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21045 Jamaicá 5960-6 Turnabout Lane death Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Wes Decedent Ever in U,S. Armed Forcas? 14. Raca - Amarican Indian, 11. Merital Status Black White etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or Neneny Injury or other traumatic event. In 1 Yas 2 No If Yes, Giva Year or Datas: 1 Never Merried 2 Married Black 1□Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Health Care Elementary/Secondary (0-12) College (1-4or 5+) Home Health Nurse 18. Nother's Nama (First, Middle, Maiden Sumama) Iris R. Hilton 17. Father's Nama (First, Middle, Last) 8 Daniel Dawkins 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9395 Indian Camp Road Columbia, Maryland 21045 19a. Informant's Name/Relationship (Type, Print) Mr. Jeff Allen Son 20b. Piace of Disposition (Nama of comatory, crematory or other place)
Columbia Memorial Park Data 20c. Location - City or Town, State 20a. Mathod of Disposition 01/18/99 Columbia, Maryland 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 □ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 M00535 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximeta Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Examiner ettending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Due to (or as a consequence of): certificate be an/Medical Dua to (or as a consequence of) Physici 23b. Did tobacco use contribute to the cause of death? ed by the detached Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part II. signed by t 4 Onknown 1 Yes 2 No 3 Probably à 24b. Wara autopsy findings available prior to 24a. Was an autopsy Completed complation of causa of death? certificate has 1 Yes 2□ No 2 □ No 25. Was casa rafarred to medical examiner? 8 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Homa \$ Residence 6 Other (Specify) 2 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? no Hospital or Attanding P. n. 24 hours after death.

The Funeral Director: After the plately filled in by the funeral Certification: After 1 CoNetural 5 Pending invastigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signatura and fitta of cartified 29c. License number 29d. Data signed (Month, Day, Year) JANUARY 12, 1999 O.C.M.E. 30. Nama and addrass of person who completed clude of death (Item 23a) (Type, Print)

THEOROPE MIKE 31. Dete filed (Month, Day, Year)

32. Registrer's Signatura

JAN 1 9 1999

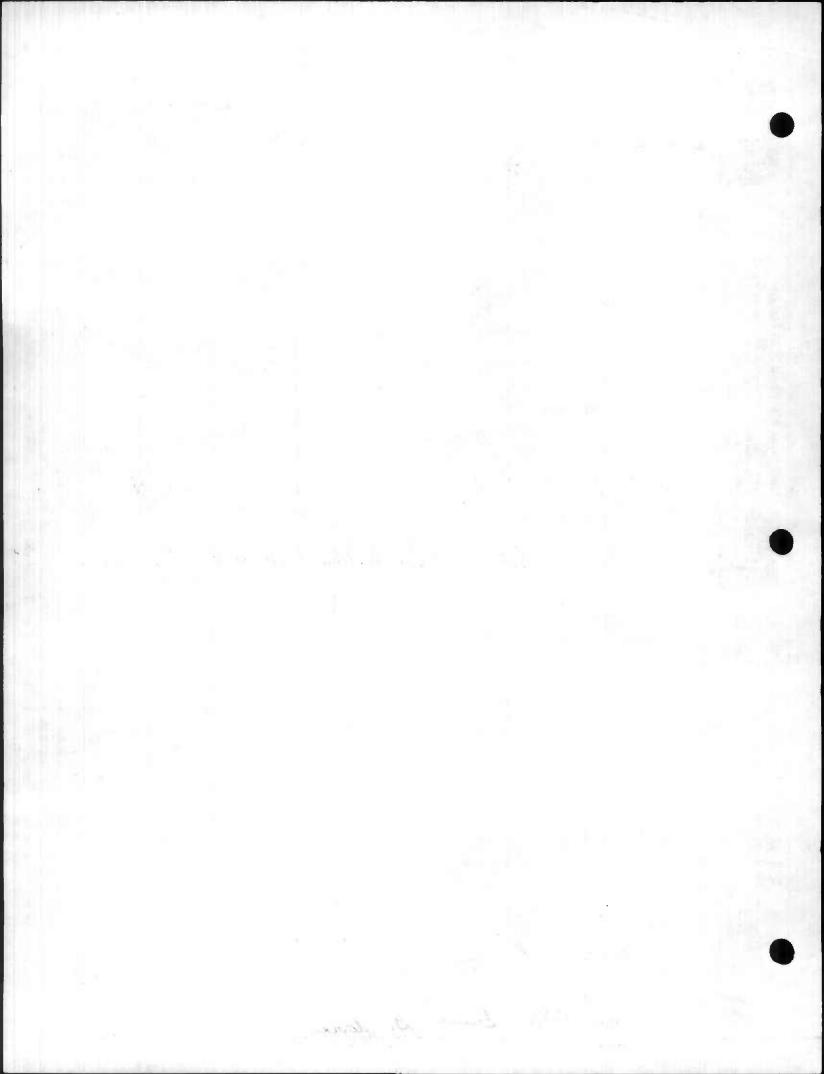
**ORIGINAL** 

111 Penn Street, Baltimore, Maryland 21201

Box 68760 Records, P.O. Division of Vital

**DHMH 16 Rev 6/95** 

State Registrar



### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Mary T. Dovle **Physician** 7: 45 pm 4c. County of Death 4b. City, Town, or Location of Daath /Medical 4a. Facility Nama (If not institution, giva straat and number) Examiner Baltimore Charlestowy Catonsville If Undar 24 Hrs. 8. Data of E Hours Min. (MARTH) center Care If Undar 1 Yaar 8. Data of Birth 9. Birthplaca (Stata or Foraign **Funeral** Sax 1□M 2XF Days Petrisylvania Director Usuai Rasidanca of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits r 28a-f show Maryland Baitimore Catonsville 1 ☐ Yas 2 No Director 10s. Street and Number 711 Maiden Choice Lane 10g. Citizan of What Sountry? 10f. Zin Code 21228 Examiner munt be r Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: permit. Pages 1 and 2 should be filed within 72 hours after doss Department of Health and Mental Hydison. Important if them 27 is marked other in any injury or other transfer other in. 14. Raca - Amarican Indian, Black, Whita, etc. White Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 X No Specify: þ 3 Widowed 4 □ Divorced 15. Dacedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retirad) Homemaker 16b. Kind of Business/Industry Home Elementary/Secondary (0-12) Collega (1-4or 5+) 18. Mothar's Nama (First, Middla, Maiden Sumame) Agnes Broschaft 17. Fathar's Nama (First, Middla, Last) Joseph P. McHugh Be 2 19a. Informant's Name/Relationship (Type, Print) Mr. Anthony Doyle, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Joyan State, Zip Code) 523 South Rolling Road Catonsville, Maryland 21228 Son 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata Data cematary, cramatory or other place) Metro Crematory 01/15/99 Baltimore, MD <sup>22. Namstack</sup>प्राक्तिकी विश्वास्तिक P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 M00535 Part 1. Entar tha disaasa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. **Physician** /Medical mediata Causa (Finai End Stage Dementia saasa or condition rasulting in daath) Years Examiner Examiner physician and s tha burial-transit The law requires that the death cartificate be asscuted Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequanca of) attanding ph Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus þ 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to complation of causa of daath? 1 Yas 2 No 1 Yas 2 No 25. Was casa rafarred to medical axaminar? 26. Plage of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Martnar of Death 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Natural 5 Panding Invastigation 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

Division of Vital Records, P.O. Box 68760, Mary Doyle N AME:

24 hours after death. within 24 ho To the Fune completaly fi

0

State Registrar

Salgrar 1. Data filed (Month, Day, Year) JAN 1 9 1999

29b. Signatura and titla of certifian

4 Homicida

(Check only one)

29a. Certifier

32. Ragistrar's Signatura

30. Name and addrass of person who copiplated causa of daath (Item 23a) (Type, Print)

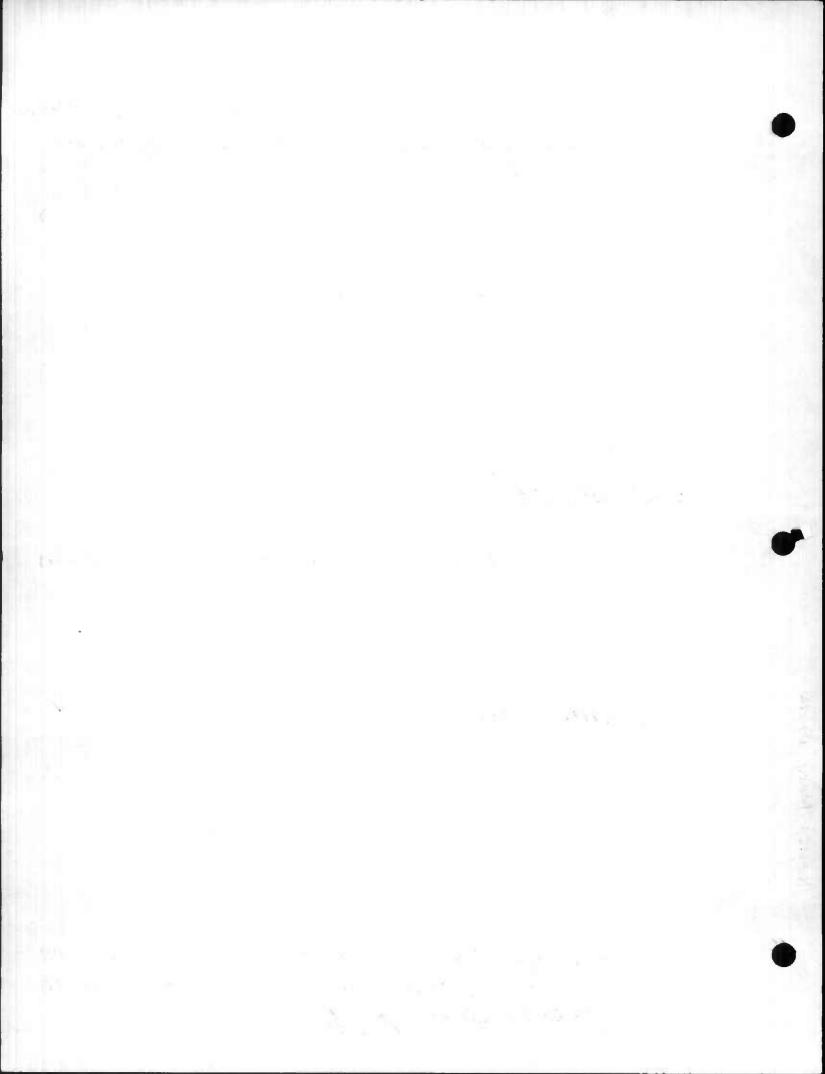
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

11 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year)

January 15, 1999

Maiden Choice lane, catonsville, MD, 21228



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** January 16, 1999 Dash 9:13 PM Alice Marie /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Severna Park
If Under 24 Hrs. 8. Date 131 Inverness Road Anne Arundel If Under 1 Yaar 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** Months Days Hours Min. 1□ M 25 F Yrs. Director 216-44-9073 88 June 12, 1910 Maryland Usual Residence of Decedent the Marylend r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Severna Park Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 r than "natural", or items 23s or the Medical Examiner must be r U. S. A. Funeral 131 Inverness Road 21146 deeth 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 10 bepartment of Health end Mental hygiene. Important: if Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examine 1 Yes 2 No If Yes, Give Year or Datas: 1 ☐ Nevar Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postal Clerk U. S. Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 2 Jackson 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Elizabeth Webster (Daughter) 131 Inverness Road Severna Park, Maryland 21146 20b. Placa of Disposition (Neme of cematery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veteran Cemetery Crownsville, Maryland 22. Name and Address of Facility Singleton Funeral Home PA 1 Second Avenue S.W. Glen Burnie, Maryland 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one hause on each line. Approximate Intervel Between Onset and Deeth Physician serten sive arters Schoolic Cardis Classica Immediate Ceuse (Finel disaase or condition resulting in deeth) /Medical **Examiner** Examiner physician and the buriel-transit death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last a to (or as a co Physician/Medical Due to (or as a consequence of 18 months 88 950 Po deteched f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed I Division of Vital Records, P 24b. Were autopsy findinga aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate hes b lirector, page 2 sl 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 □Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? Certification: After Attending 5 Pending Invastigation 1 Neturel death. 1 TYes 2 No 2 Accident efter deat 6 Could not be determined 3 Suicide 28f. Location (Straet end Number or Rurel Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide ò filled in 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and placa, and due to the cause(s) and manner es steted. 29a. Certifier edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. 29b. Signature and title of certifian 29d. Date sighed (Month, Dey, Year) aco. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mascdena 32. Registrar's Signature State Registrar

DHMH 16 Ray 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Nema (First, Middla, Last) 3. Time of Deeth 10:30 pm Eileen Elliott JAN 14 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimor If Under 24 Hrs. Center Mercy Me 5. Social Security Number Medical Baltimore City If Under 1 Yaar 9. Birthpleca (Stete or Foreign Country) 7. Age (In yrs. last birthdey) 6. Sex 8. Dete of Birth (Month, Dey, Year) Deys Hours Min 1 M 2 XF 239-26-7737 Yrs. 74 March 9 1924 Virginia Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore 1 ☐ Yes 2 No Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7844 Wynnbrook Road USA 21224 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yas 2 ☑ No If Yes, Giva Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 8th Cosmetologist Beauty Salon 17, Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) General Dewey McMahan Minnie Edwards 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Leon Elliott / husband 7844 Wynnbrook Road Baltimore Md. 21224 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 ABuriel 2 Cremetion 3 Remove from State Oak Lawn Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 1/18/99 Baltimore Md. 21. Signeture of Funerel Service Licensas 22. Neme end Address of Fecility Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart feilure. List golf one ceuse on each line. 300 Mace Ave Baltimore Md 21221 Approximate Intervel Between Onsat and Death Immediete Ceuse (Fine) disaasa or condition rasulting In deeth) una Cancer Due to (or as e consequence of): Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Due to (or as e consequence of): Pert II. Other algrifficent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Qnknown 24b. Were eutopsy findings aveilabla prior to 24e. Wes en eutopsy performad? completion of cause of deeth? 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 28. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun

**Physician** 

· /Medicat

Examiner

Director

Funeral

PV

Completed

Be

**Funeral** 

Director

with the Maryland

d 2 should be filed within 72 hours efter death with the Marylan Ihygiene. The merked other than "natural", or items 23a or 28a-f show traumatic event, me Mexical Exercise must be notified at traumatic event, me Mexical Exercise must be notified at

Baltimore, Maryland 21215-0020

Examiner Physician/Medicai 88 by Completed director, Be Lo Certification:

physicien and the bunal-transit certificata be executed usa signed by the e peen hes certificate funeral Attending death. after death Director: A To the Hospital or Atter within 24 hours after der To the Funeral Director completaly filled in by th

P.O.

Division of Vital Records.

State Registrar

Medical

28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dev Year) 1 Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner es stated.

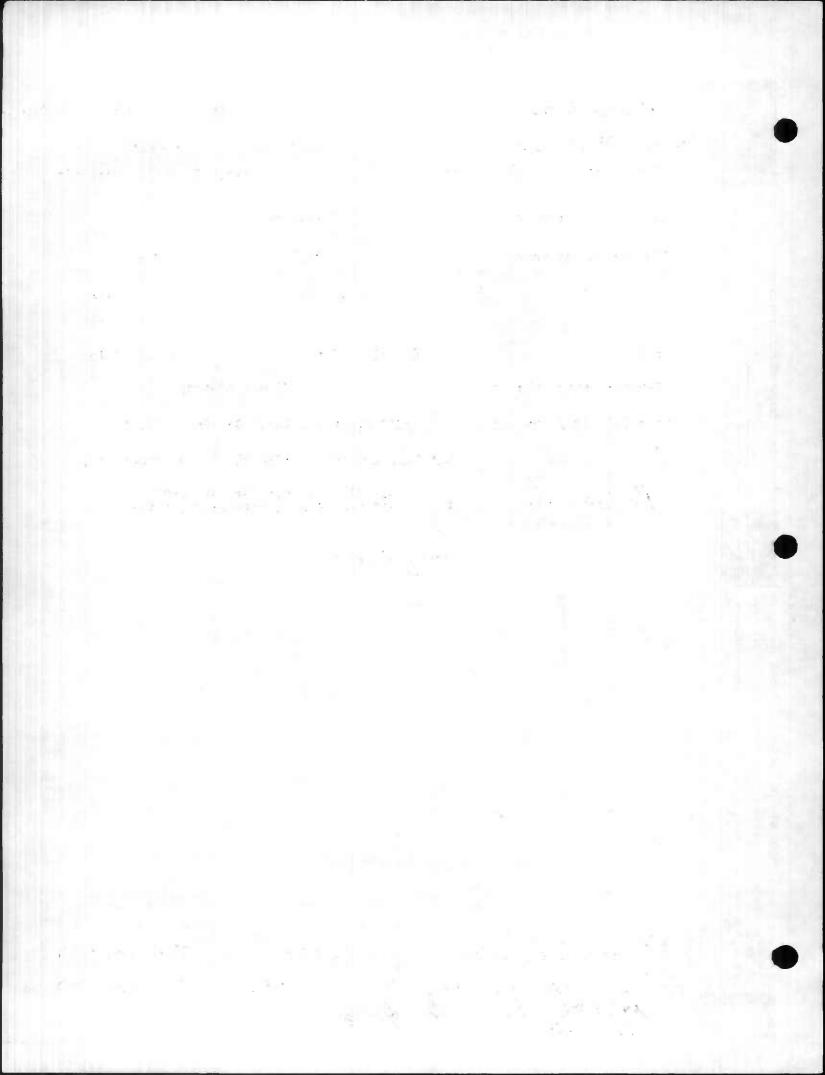
Medical Examiner: On the best of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date end plece, and due to the ceuse(s) end menner stated. 29b. Signeture end title of certifier 29c. License number

29d. Dete signed (Month, Dev. Year)

amora 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 10217

Jan

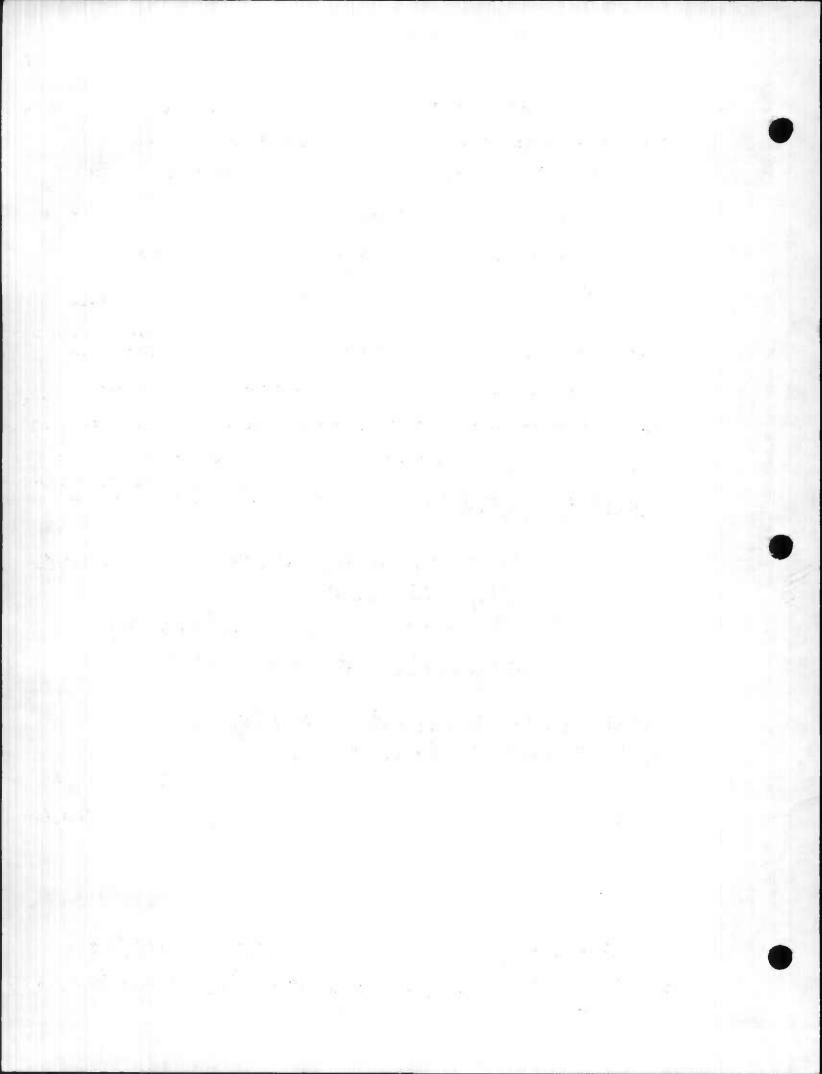
M. D. Mercy Medical Center, 361 St. Paul Place, Bolto, MD 132. Registrar's Signature Kamona F Swaby, M.D.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 07721

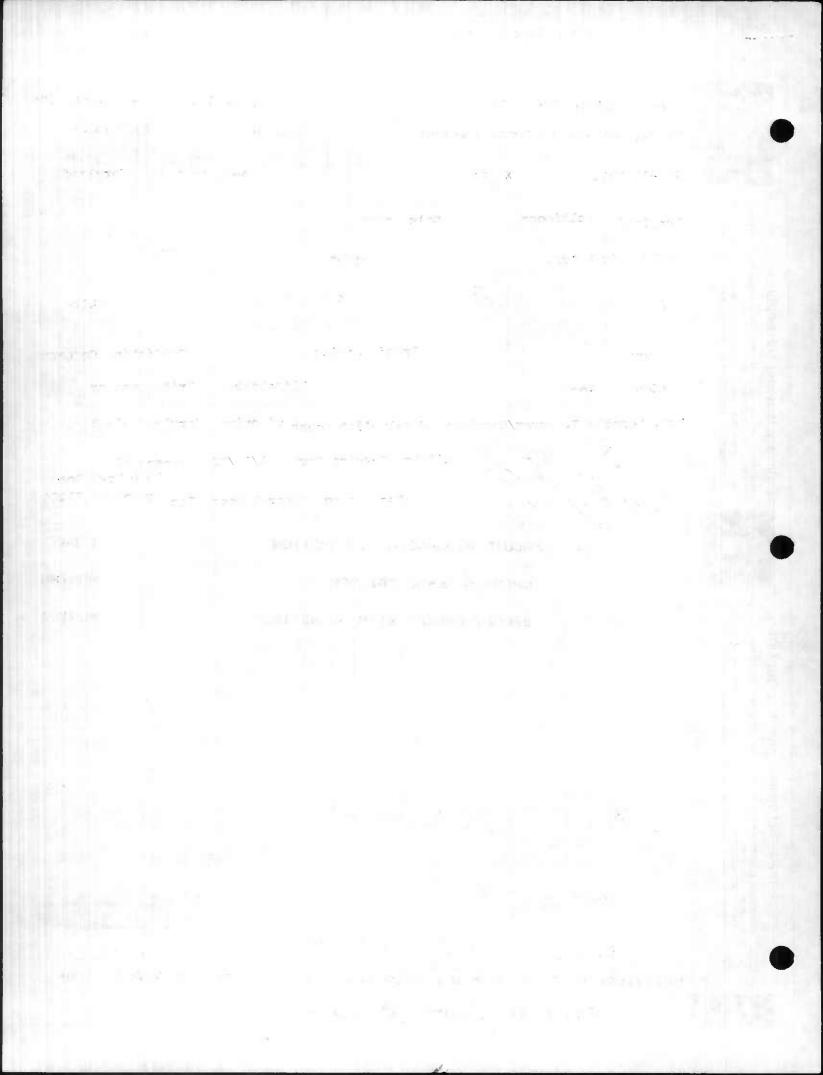
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-40-6320 Tace of Decedent	<b>2</b> M 2 □ F 5	3 Yrs.	Monda's Days	Tiours Iviii.	12-2	5-45	ME	3″
10b. County	1	Oc. City, Town or	Location				10	Od. Inside City Limits
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itus	12. Wes Decedent Eve Armed Forces?	er in U,S.	B. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Spen, Mexican, Puert	pecify Yes or No	- 14. Rece Black	- America , White, e	
Married 2 Married ved 4 □ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No		, , , , , , , , , , , , , , , , , , , ,	Specify:	Bla	
15. Decedent's Ed	fucation	16a. De	cedent's Usual Occu	pation	kina	16b. Kind of Bus		
(Specify only highest grade completed)  Elementary/Secondery (0-12) College (1-4or		40r 5+}		sual Occupation work done during most of working Tuse retired)		Baltimore		
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t's Name/Relationship (								Code) 21213
L S. Feath	erstone	121	3 N. Che	ester St	reet B	altimor		Maryland
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tion 5 ☐ Other (Specif		Arbut		1	01-19-	99 ALD	ucus	5 / 11 D
21. Signature of Funeral Service Licensee  22. Name end Address of Facility  Baltimore, Maryland 2:  WM.C.March FH 1101 E. North Avenue								
mentile disease or com r heart failure. List only	Casoms was cabsed to	Min. Do not	enter the mode of dy					Approximate Interval Between
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Ignificant conditions c	ontributing to death but I	not resulting in the	underlying cause g	iven in Part I.	23b. Did	tobacco uss con	tribute to	the cause of death?
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Deeth al 5 Pending ent Investigation	Hospitel: 1 ☐ Inpatient  28a. Date of Injury (Month, Dey )	2 ER/Outpat 28b. Time Injur	of 28c. Injury		lome 5 Resi 28d. Describe	dence 6 Othe how injury occurre	-	Koad,
de 6 Could not be determined	28e. Place of Injury building, etc.	At home, farm, (Specify)	street, factory, office		28f. Location ( City or To	Street and Numbe wn, Stete)	er or Rurei	l Route Number,
Cartifying Ph	ysician: To the best of r ninar: On the basis of en and manner state	amination and/or	ath occurred et the investigetion, in my	time, date end place opinion, deeth occu	e, end due to the arred at the time,	ceuse(s) end mer date and piece, a	nner as stand	sted. the csuse(s)
and tille of cegitter	and manner state		29c. Licer	se number		29d. Date signed	(Month, L	Dey, Year)
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address of personnum	completed cause of dee	th (Item 23e) (Tur	ne. Print)	- 112		1,2		
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(Month, Day, Yeer)		Signature	The same		Mel	NUNC	-1-1	0 11 11
	SANG Month, Day, Yeer)	Month, Day, Yeer) 32. Fegister:	Month, Day, Yeer) 32. Register's Signature	And 1 9 1999 And 1 1 9 1999	AANG MONTH, Day, Yeer) 32. Register's Signature	SANG MONTH, Day, Yeer) 32. Flegist It's Signature	SANG My Jack Helow Ave Boltimore	SANG M. D. J. St. Hefor Ave Boltinger

Registrar



State of Maryland / Department of Health and Mental Hygiene
0 1111 -1 - 1 - 11

	1. Decedent's Neme (First, Middla, L.	nst)		00/11/10	ate of		2. Data of De			ima of Death	
Physician /Medical	ANNA ELIZABET	H FREY					JANOARY	/ P≥, 19	999 6:1	Ø PM	
Examiner	4e Fecility Neme (If not institution, gi Saint Joseph N	va street end number) ledical C	enter			4b. City, Town, or TOWSO		4c. County	of Death RICIMOR	е	
uneral irector		Sex 7. Ago 1 M 2 F 92	e (In yrs. last i	Yrs. If U	nder 1 Year ths Days		8. Date of Bir (Month, De Aug. 10		9. Birthplece (S Country) Marylar		
show	10a. Stete 10b. County		10c. City, To	wn or Location					10d. Ins	ide City Limits	
28a-f shonorfiled at	Maryland Baltin	nore	Hal	ethorpe	9				1	Yas 2 No	
or 28	10e. Street and Number			10f	Zip Code			10g. Citizen of \	Whet Country?		
23a	5736 First Ave.			2	21227			USA			
ar, or items 23s or 28s-f s Examiner must be notified by Funeral Director	11. Merital Status  1 Never Married 2 Merried  3X Widowed 4 Divorced	12. Was Decadant   Armed Forcas?  1  Yes 2  If Yas, Giva Yaer or Detes:		if Yas,	specify Cub	Hispanic Origin? (Span, Maxican, Puar Specify:	specify Yas or No to Rican, etc.)	Biad	14. Reca - Amarican Indien, Black, White, etc.  Specify:  White		
natur edical	15. Decedent's E (Specify only highest gi Elementery/Secondery (0-12)	s Education grade completed)  College (1-4or 5+)		16a. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired)							
vent, me M	6 yrs.			Proof R	eadin	1			hing Com	pany	
ever Be	17. Fethar's Neme (First, Middle, Las	()				Elizabe	me (First, Middle,				
is marked or raumatic eve To Be	Adam Koch	(Time Brint)		Ob. Malling Add	race /Ctrac	t end Number or R		Fritzen			
7 is r	19e. Informent's Name/Relationship Mrs. Dorothy J. F					ourt Time					
important: if item 27 is marked other any injury or other traumatic event, once.  To Be C	20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3	Removel from Stata	20b. Plece came	of Disposition tery, cremetory	(Neme of or other pla	rca)	Dete	20c. Location -	- City or Town, St	ata	
Important: any injury ance.	4 Donetion 5 Other (Special Signature of Fugure) Service Lice		7				14/99	Towson	,Md. O York R		
any i	22. Name end Address of Facility 1050 Yor Ruck Towson Funeral Home, Inc. Towson, N										
	23a. Part 1. Enter the thoursa, or con shock, or heart failure. List only	nplications that caused	the deeth. D	o not enter the	mode of dy	ing, such as cardie	c or respiretory e	rrest,	Appro	oximete rai Between	
sician edical miner	tmmedlete Ceuse (Finel disease or condition resulting in death)	CHRONIC	Due to (or es	e consequenca	of):	RCTION			1 I	AY NTHS	
s the burletransit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	Due to (or es e consequence of):  BREAST CANCER WITH METASTISIS  MONTHS								NTHS	
016	Ceuse (Disease or injury that initiated events resulting in deeth) Last	Due to (or es e consequenca of):									
for use											
ed by the detached	Pert II. Other eignificant conditions	contributing to death be	ut not rasulting	in the underlyi	ng cause g	iven in Part I.		Yee 25 to	3 Probably	4 Unknow	
els has been signed by the attendin page 2 should be detached for use Completed by Physician/M							24e. Wes	en autopsy ormed?	24b. Wera au available completi of deeth	prior to	
certificeta has rector, page 2 Be Comp							10	Yes 2000	1 ☐ Yes	250 No	
director, p	25. Was case referred to medical examiner?					26. Plece of De	eth (Check only	one)		/	
this ce al dire	1 Yes 25 No	Hospitei: 1 Inpatie	nt 2 ER	Outpetient 3	DUA		dome 5□ Resi				
After	27. Menner of Deeth  Naturet 5 Pending  and Investigetic	(Month, De	28e. Date of Injury (Month, Dey Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No				28d. Describe how injury occurred				
To the Funeral Director: After toompletaly filled in by the funeral Medical Certification;	3 ☐ Sulcide 4 ☐ Homlcide  6 ☐ Could not be determined  28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, Stete)				
edical	29e. Certifier (Check only one)  Certifying P  Certifying P  Certifying P	hyeician: To the best ominar: On the basis of and mannar sta	examinetion	lge, deeth occur end/or investige	rred et the t etion, in my	ime, dete end plec opinion, deeth occ	a, end dua to the urred at the time,	ceuse(s) end me dete end plece,	enner es stated. and due to the c	ause(s)	
Media	29b. Signeture end title of cartifier							29d. Data signe	ed (Month, Dey, 1	'ear)	
28	29b. Signeture end title of cartifier  Matindad W. de Lean, m. J., D19508							29d. Data signed (Month, Dey, Year)			
28 -	30. Neme and eddress of person who	W, de I	poth flow 22	M du,				1101	77		



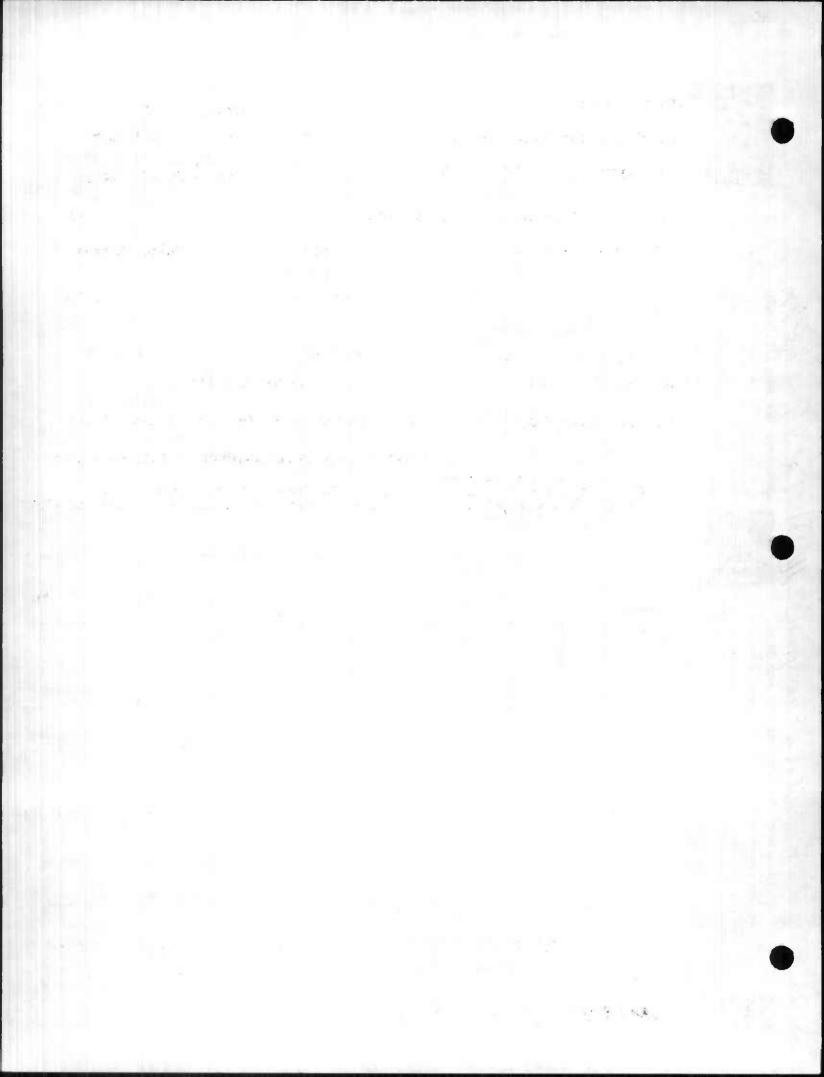
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State of Maryland / Department of Health and Mental Hygiene

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				Certificate	of Death		Reg. No.		71.0
Physician /Medical	1. Decedent's Name (First, Middle, La Sonya L. Feeser			Day 15, 1999	Yaar	3. Tima of Death 6:00am			
miner	4a Facility Name (If not institution, given Hospice of Balti	4b. City, Town, or Location of Death Towson, MD  4c. County of D  Balti				Death imore			
eral ctor	5. Social Security Number 6. S 219–28–1273 Usual Residence of Decedent	Sex 7. Ag	e (In yrs. last birth 74 Yı	Months D		Min. (Month, D	rth ey, Year) y 17,1924	9. Birthol Coun Ital	lace (State or Foreign try) LY
tor	10a. State 10b. County	mpia	10c. City, Town					10	0d. Inside City Limits  1€ Yes 2 □ No
23a or 28a-f sh ust be notified. al Director	10e. Street and Number 5051 Grande Drive	, A-4		10f. Zip Co	ode 32504		10g. Citizen of V United		
by Funera	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedant Armed Forcas? 1 ☐ Yes 2 전 If Yes, Give Yaar or Dates:		13. Was Deceden If Yes, specify	Cuban, Maxicen,	in? (Specify Yes or N Puerto Rican, etc.)	Blac	14. Race - American Indian, Black, White, etc. Specify: White	
Completed	15. Decedent's E (Specify only highest gra Elementery/Secondary (0-12)	ducation ade completad) College (1-4or s		6e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired)			16b. Kind of Bu	siness/inc	dustry
Be	12 17. Fathar's Nama (First, Middle, Last Ermenegildo Ric	0		Homen	maker Own Ho			ome	
To	19a. Informant's Name/Relationship (	Type, Print)			Street and Number	or Rurel Route Numb	ber, City or Town,		Code)
	20a. Method of Disposition  1 Burial 2 Cremation 3 C  4 Donation 5 Other (Specie	Removal from Stata	20b. Place of C	Disposition (Name cremetory or other	of erplace)	Date Cy 16,1999	20c. Location -	City or To	
Physician/Medical Examiner	23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leeding to immediate cause. Enter Undertying Cause (Disease or Injury thet initiated events resulting in deeth) Last	a. en b. Civ c. Ch	Due to (or as a co	insequence of):  I the insequence of):  H and insequence of):	ver d liver titis (	is ease	etion		Approximate Interval Between Onset and Death  3 years  uninerval
by Physician	Part II. Other eignificant conditions of	contributing to death b	ut not resulting in	ha undarlying cau	se given In Part I.		Yes 20 No	3 □ Prol	the cause of death?
Completed						24a. Wa	s en autopsy formed?	av.	ere autopsy findings ailable prior to mplation of cause death?
To Be Com	25. Was cese referred to medical examiner?  1  Yas 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outp	patient 3 DOA	Other:	of Death (Check only sing Home 5 \sum Res	_/	1 C	Yes 2 No
ion:	27. Manner of Death  1 Interval 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	28d. Dascribe how Injury occurred  No  28f. Location (Street and Number or Rural Route Number, City or Town, State)							
completely filled in by the Medical Certifical	29a. Certifier (Check only one)  1 Certifying Pl 2 Medical Example of certifier  29b. Signature and Use of certifier  30. Neme and eddress of person who	niner: On the best and manner st	f examination and	for Investigation, in	my opinion, death	place, and due to the hoccurred at the time	29d. Data signe	and dua to	Dey, Year)
State	2), A. R. Ley 31. Date filed (Month, Day, Year)	GBINC	6767	N.C.	horder	St. Br	alta, 1	ud	21204



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death Month Kickey Furley 0748 01 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE RACTMORE If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) OF MARYLAND MEDICAL CENTER UNNERSITY 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 8. Sex Birthplace (State or Foreign Country) 1X M 2□ F Months Days 44 214-60-2185 Yrs. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Edgewater Anne Arundel 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 450 Walnut Drive 21037 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritel Stetus Bleck, Whita, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2] No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grads completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HVAC Sheet Metal Mechanic 11 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Charles T. Furley Jean Elizabeth Robinson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Anne Furley - Wife 450 Walnut Drive, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removel from Stete Lakemont Memorial Gardens 01/23 4 ☐ Donetion 5 ☐ Other (Specify) Davidsonville, MD 21. Signeture of Funeral Service Licensee 22. Neme and Address of Facility Hardesty Funeral Home, P.A. ne La 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) Hennorhagic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initieted events rasulting in death) Last Due to (or as a consequence of): Failure Herotic Due to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 NO 1 ☐ Yes 2X No 26. Place of Death (Check only one) Hospitel: 1 Senpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work?

Examiner attending physician and for use as the burial-transit certificate be asscuted Box 68760 Physician/Medical P.O. Records, Completed Deen 788 page 2 certificate Division of Vital or Attending Physician: Be edical Certification: To this After after deeth.

Director: Afted in by the fun To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by

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**Physician** 

/Medical

**Examiner** 

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**Funeral** 

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28a-f

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"natural", or

Hygiene. other then filed within

permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If them 27 is marked other any Injury or other traumatic event.

**Physician** 

/Medical

Examiner

72 hours after

Maryland 21215-0020

Baltimore,

Renal 25. Was case referred to medical examiner? 1 Yas 2 No 27. Manner of De 5 Pending investigation 1- Netural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. 29e. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

18

1999

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

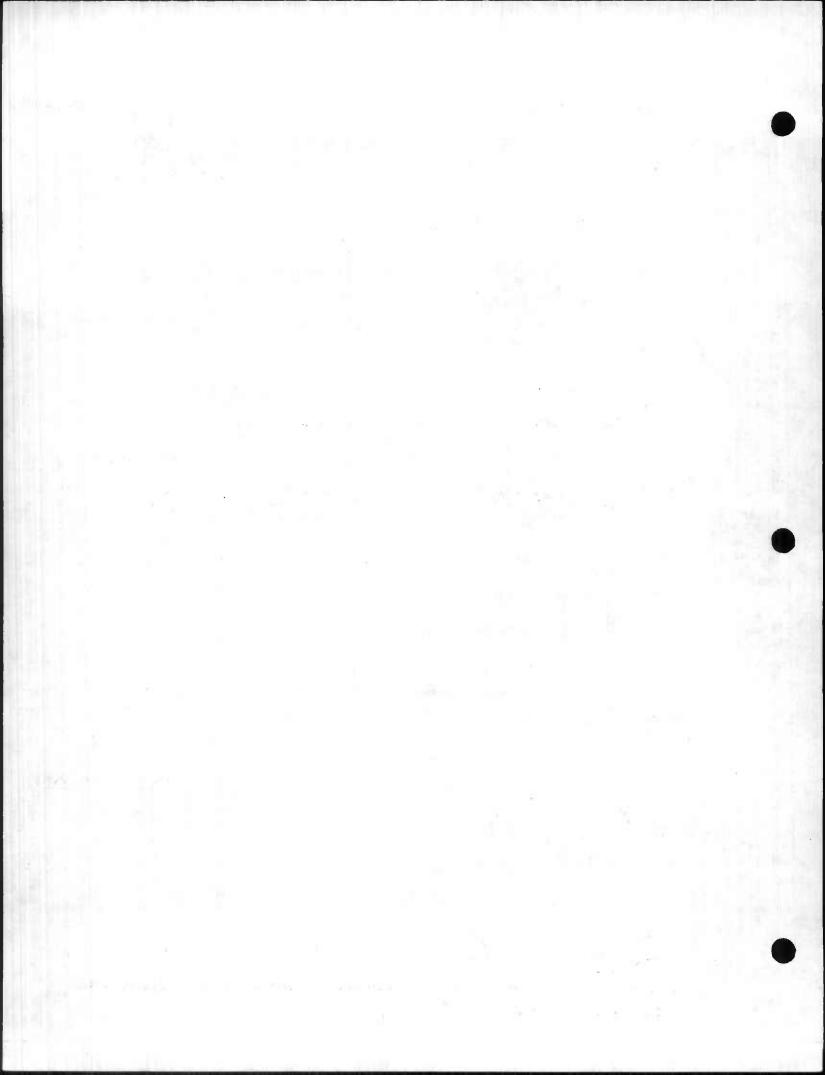
GREEVE STREET DAVID WEINREICH MD 22 SOUTH 31. Date filed (Month, Day, Year)

State Registrar

JAN 1 9 1999

29b. Signature and titla of certifier

32. Registrer's Signeture



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Nema (First, Middla, Last) Day 9:15 A.M 14, 1999 4c. County of Death James Leonard Fabian 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 4, 1928 1115 Bayard Street 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) Months Yrs. 70 Maryland 219-22-1134 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Md. N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1115 Bayard Street 21223 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1∆D Yes 2 □ No If Yes, Give Yaar or Dates: 1951 Was Decedant of Hispanic Origin? (Specify Yas or No. If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Race - Amarican Indian. 11. Marital Status Black, White, etc. 1 Nevar Marriad 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Teamsters Local 557 Truck Driver 6th 18. Mother's Nema (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Emma Virginia Horlacher Joseph Walsh Fabian 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1115 Bayard Street Baltimore, Maryland 21223 Edna Lee Fabian ( Wife ) 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 1/18/99 Baltimore, Maryland of Fysieral Service Licensee Kevin E. McCully-Polyniak Funeral Home P.A. Ecker 237 E. Patapsco Ave. Baltimore, Md. 21225 23a. Párt1. Enter the disease, or complications that ceused the death. Do not entar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Hypoxem 1 a Due to (or as a consequence of): Chronic obstructive lung diseases 23b. Did tobacco use contributs to the cause of death? Yae 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 26. Place of Deeth (Check only one) Hospital:

**Physician** /Medical Examiner attending physician and for use as the bunal-transit The law requires that the death certificate be executed

À

signed b

been signature

is certificate has be director, page 2 s

al or Attending Physician: T s efter death. il Director: After this certificat ed in by the funeral director, p

To the Hospital or A within 24 hours efter To the Funeral Directompletely filled in b

Examiner

Physician/Medicai

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Completed

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Certification:

edicai

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**Physician** 

/Medical

Examiner

**Funeral** 

Director

ir than "natural", or items 23s or 28s-f show.

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examples must.

altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Directo

Funeral

by

Completed

2

with the Maryland

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

25. Wes cese referred to medical examiner? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending Investigation 1 Tyes 2 No 2 Accident

6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Scartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signatura and little of certifier 29c. Licansa number

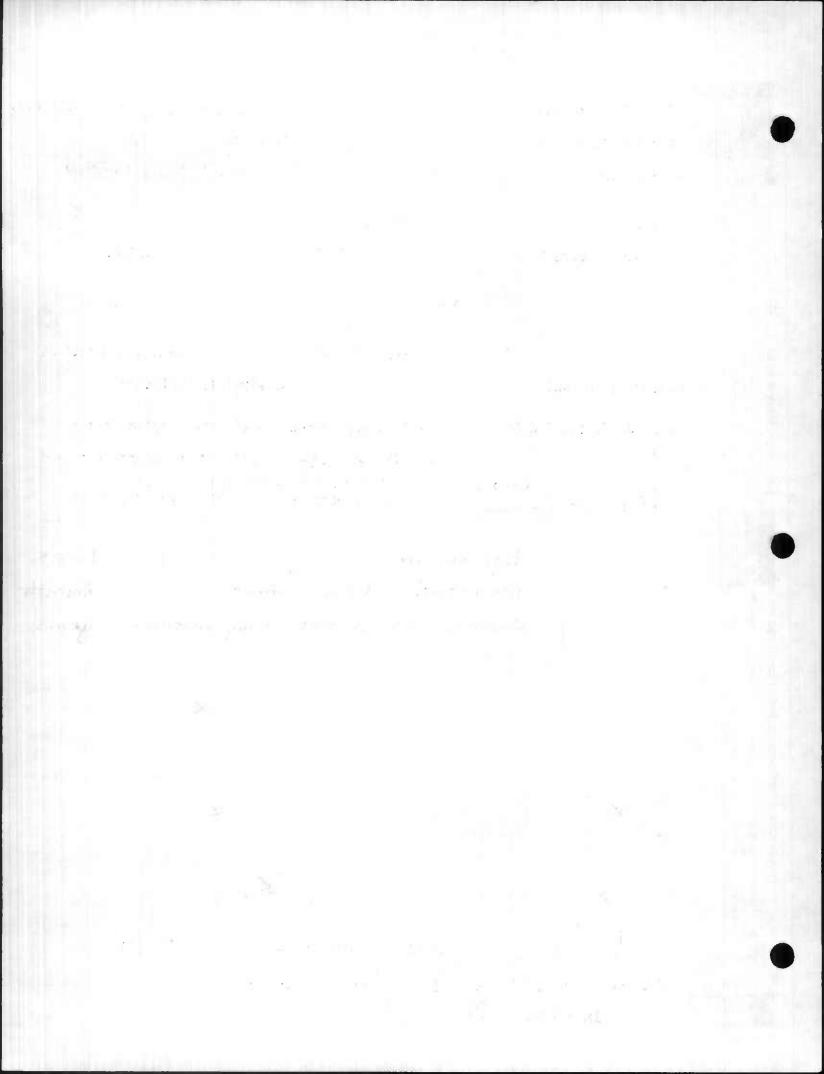
1115

MD ess of person who completed ceuse of death (Item 23a) (Type, Print) 30. Name and add

Jule Muneses 3721 Potee Street Baltimore, Maryland 21225

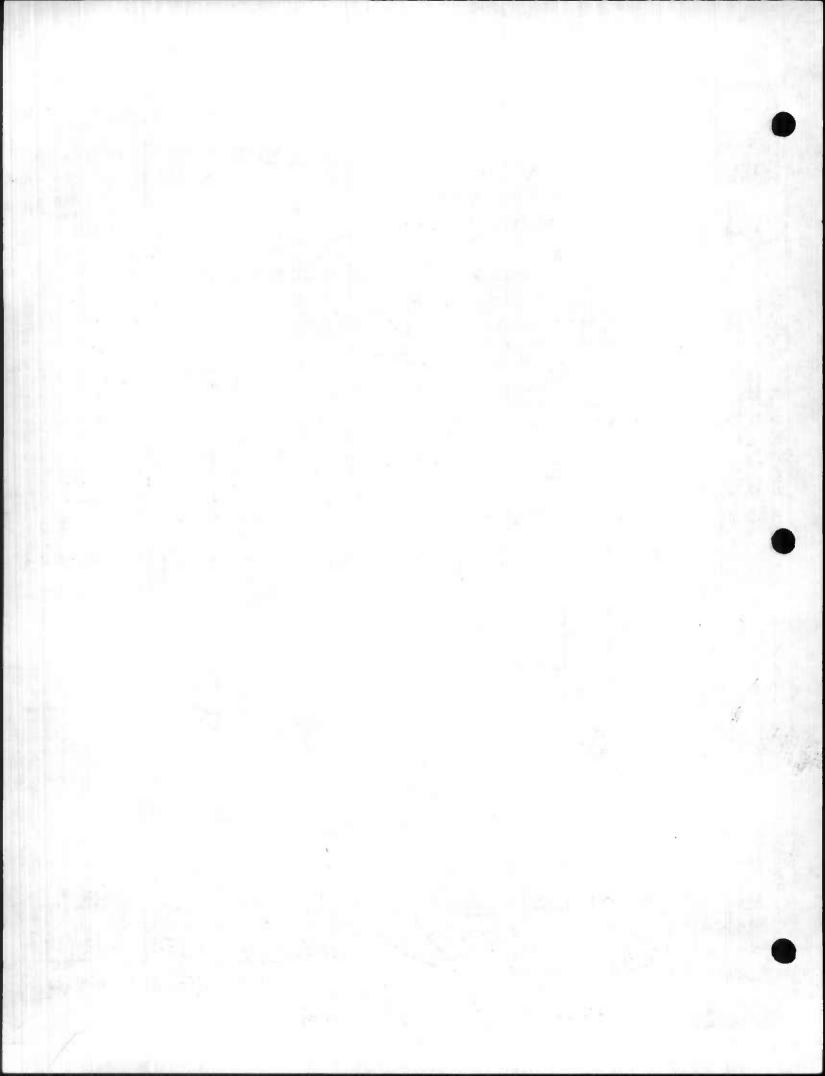
31. Date filed (Month, Dey, Year) 32. Registrar's Signature JAN 191999

State Registrar



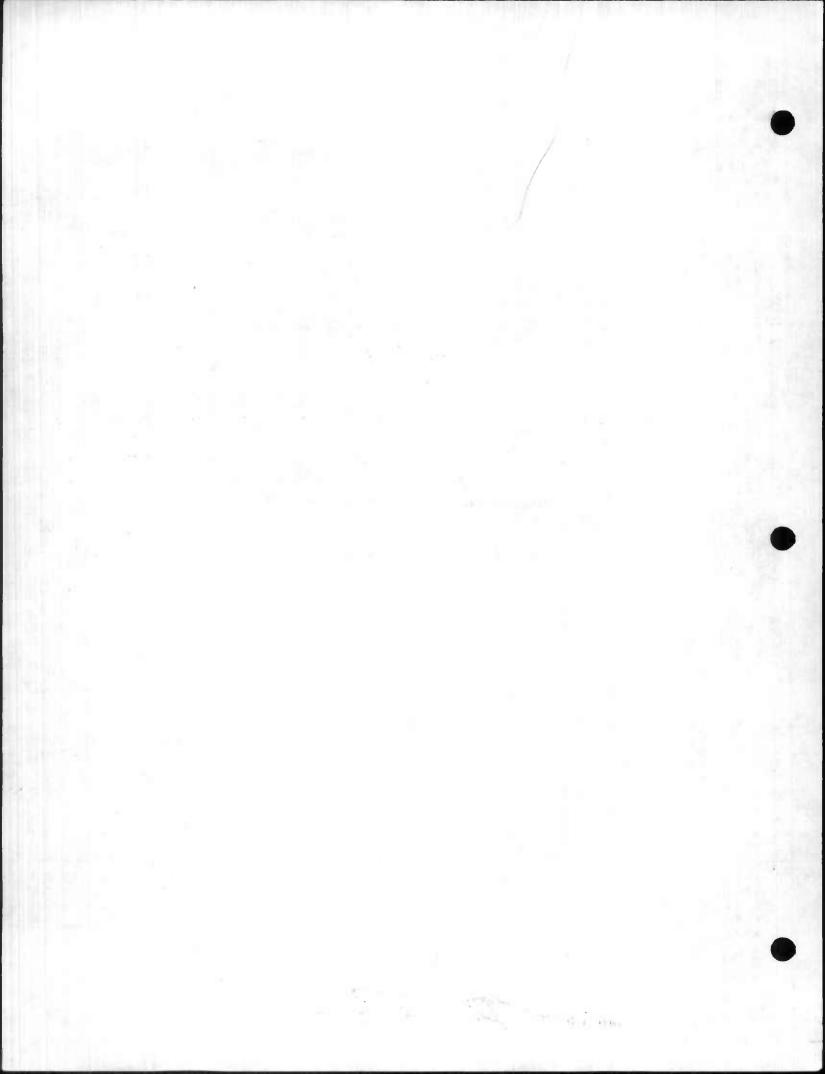
State of Maryland / Department of Health and Mental Hygiene

		Otate	Ce	rtificate of Dea	4h	Reg. No.	00729			
	Physician	Decedent's Name (First, Middle, Last)     Char	2. Data of Dea Month	Day Year						
	/Medical Examiner	4a Facility Name (If not institution, give street and n			January Town, or Location of Death					
	Examilie	137 N. Meadow Drive		G1	en Burnie					
	Funeral Director	5. Social Security Number 6. Sex 102 M 2 F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year If Under Months Days Hour	der 24 Hrs. 8. Data of Birth rs Min. (Month, Da April	v. Year)	irthplace (State or Foreign Country) Maryland			
deeth with the Meryland rite 23e or 28e4 ehow r mant be notified at	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits				
	Men Tot	Maryland Anne Arundel	Glen Bu	rnie			1 ☐ Yes 2 No			
	234 or 28 234 or 28 and be no	10e. Street and Number 137 N. Meadow Drive		10f. Zip Code 21060		10g. Citizen of What Country? U.S.				
	ar, or he	1 Never Married 2 Married 1 Never Married 2 Never Married 2 Never Married 1 N	2 No Koroan	Was Decedent of Hispanic If Yes, specify Cuban, Mexi 1 ☐ Yes 2 XNo Spec	Origin? (Specify Yes or No- ican, Puarto Rican, etc.) city:	14. Race - Arr Black, Wh Specify:	nerican Indian, nita, etc. White			
15-0	"natural".	15. Decedent's Education (Specify only highest grade completed	) (Give	dent's Usuel Occupation kind of work done during n	most of working	16b. Kind of Busines	s/Industry			
2121	with the party of	Elementary/Secondary (0-12) College 6th	(1-4or 5+)	intenance		General F	Refractories			
b	EIPE A	17. Father's Name (First, Middle, Last)		other's Name (First, Middle,	ner's Name (First, Middle, Maiden Sumame)					
yiai		Charles	Zula Made	Zula Madeline Woodart						
Mar	2 sh	19a. Informant's Name/Relationship (Type, Print)			mber or Rural Route Number					
	Teat Fe 2	Doris Fant / wife		N. Meadow Dr  osition (Name of matory or other plece)	Data Data	20c. Location - City of	yland 21060 or Town, State			
	Ty or	1 Surial 2 Cremation 3 Removat from 4 Donation 5 Other (Specify)	Md. Stat	e Veteran Ce	1		le, Maryland			
Bai	Departm Departm Importm eny inju	21. Signature of Funeral Service Licensee	- //	2. Nama and Addrass of Fa 001 Ritchie	<sup>acility</sup> Gonce E H <b>i</b> ghway Balt	Funeral Horizone, Md.				
4	Physician /Medical Examiner	23a. Part1. Enter the disease, or control allons that shock, or heart feiture. Les only one cause on Immediate Cause (Finat disease or condition resulting in death)		er, Adeno	cascinon Ce		Approximate Interval Between Onset and Deeth			
68760,	fileste be executed 3 physicial And se the burletraneit edical Examiner									
×	2 0 -	d					1			
Box	death e etten ed for u	Part II. Other significant conditions contributing to	doubt but not reculting in the	inderheing course cives in Re	and 295 Dide	obacco una contribu	rte to the cause of death?			
P.0	ed by the detection of Physics	Tall it. Substituting to the substituting to t		1)2Yes 2 No 3 Probably 4 Unk						
ord	9 8 W D					an autopsy med?	Were autopsy findings available prior to completion of cause of death?			
E	Com				101	res 2000	1 ☐ Yes 2 ☑ No			
VIta	certificate rector, pag	25. Was case refarred to medical axaminer?		1	lace of Death (Check only o	ne)				
ō	fing Physicien:  After this certific funeral director, fone. To Be	27. Manner of Death  Natural 5 Pending  28a. Date (Mo	Inpatient 2 ER/Outpatie of Injury nth, Day Year)  28b. Time of Injury	28c. Injury at Work?		dence 6 Other (Sp now injury occurred	pecify)			
<u> </u>	To the Nephtial or Attending Physicien: The inviting 4 hours eiter death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.  Medical Certification: To Be Com-	3 Suicide 6 Could not be	M 1 ☐ Yas 2 ☐ No  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, Stete)				
	To the Hospital within 24 hours To the Funeral completaly filled Medical Ce	29a. Certifier (Check only one) 15 Certifying Physician: To the 2 Medical Examiner: On the and mai	e best of my knowledge, deat basis of examination and/or in oner stated.	h occurred at the time, date westigation, in my opinion, o	a and place, and due to the deeth occurred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)			
	Within Comp	29b. Signature and title of certifier	1/2/	29c. License numb	per 1551	29d. Data signed (Mo	nth, Day, Year)			
	6x1	30. Name and address of person why completed cau	use of death (Herri 23s) (Type,	Print) UD S- (CD)	i Hi aharay	Galon (1	a Busia Calinol			
	State Registrar	31. Date filed (Month, Day, Year) JAN 19199	Register's Signature	4. South	, July	17 00 19	(42.14)			

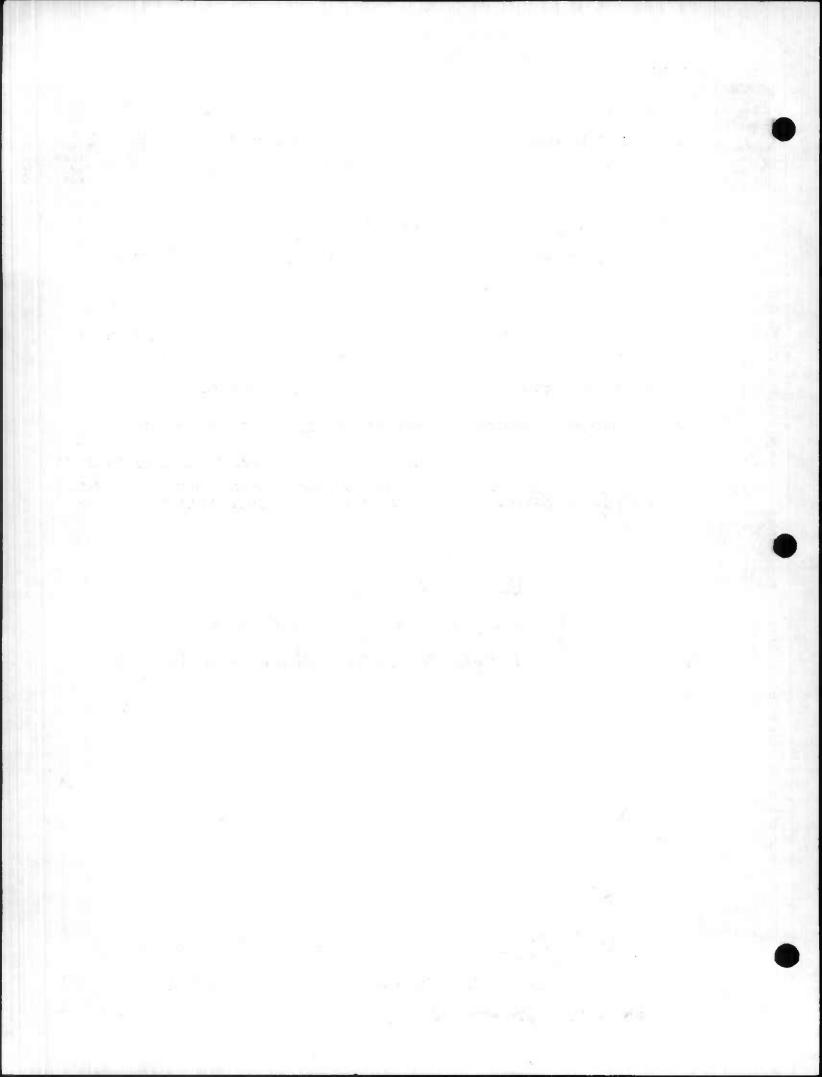


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Franz Raymond 15 1999 3:00 A.M. January /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Genesis Elder Care Hammonds Lane If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Days Months Hours 1XM 2□ F 207 97 2001 80 Director August 10,1918 Maryland Usual Residenca of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "naturel", or heme 23e or 28e-f shor the Medical Examiner must be notified at 1 Yes ZX No Anne Arundel Baltimore Directo Maryland 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 4209 - 4th Street 21225 U.S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White ğ 3 ☐ Widowed 4 X Divorced Yeer or Dates Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Laborer Md. Ship & Dry Dock Unknown permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy
importants if them 27 is marked offer any Injury or other 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 88 2 Clarence Franz (not available) 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robert Kantorski 4209 - 4th Street Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 1/18/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. 23a. First: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Baltimore, Md. 21225 Approximate tnterval Between Onset and Death **Physician** /Medical 2 YEARS Immediate Cause (Final LUNG CANCER disease or condition resulting in death) **Examiner** Due to (or as e consequenca of) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es a consequenca of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to Completed 24a. Wes an eutopsy performed? peeu completion of cause of death? page 2 1 ☐ Yes 2 ☐ No 1 Yes 2 TING certificate Division of Vital after death.

Director: After this certifica 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Inversing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 PNatural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 ☐ Could not be determined 28l. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide Hospital
 24 hours a
 Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical pletely (Check only one) within 2 \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21776 D Newa JANUARY 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) HANOVER. ST RALTIMORE ZIEZY 3001 MUNDRA 2 Strar's Signeture 31. Dete filed (Month, Dey, Year) State Registrar 1 6 1000



hysicia		FH Film 767 1-19-9	-		061	tificate of	Dealli	_	Reg. No.	00701							
/Medica		Decedent's Name (First, Middle,  EVELYN	, Last)	FALBO	ORN			2. Date of De Month JAN.	Day	Year 999 1045.							
/Medica Examine	_	4e. Fecility Name (If not institution,			J1(1)		4b. City, Town, or L		Wash	nington							
Funeral		16505 Virginia A 5. Social Security Number		. Age (In yrs.	last birthday)	If Under 1 Year	Williamsp	8. Date of Bird (Month, Da	Wash	9. Birthplece (State or I							
Director		065-10-8660	1□M 2Ã1F	80	Yrs.	Months Days	Hours Min.	AUG 7	1918	Country) NY							
	1	Usuel Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City							
	by Funeral Director	þ	MD Washin	aton	WI	LLIAMSI	PORT				1 ☐ Yes 2						
			10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Country?						
			16505 VIRGINIA	12. Was Deced	lent Ever in U	l.s. 13. v	Ves Decedent of	795 Hispanic Origin? (Sp	pecify Yes or No		SA - American Indian,						
EX.			þ	é	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Force  1 Yes 2  If Yes, Give  Year or Dal	No No	11	Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)		WHITE				
Jical Ex	eted	15. Decadent's (Specify only highest	s Education grade completed)		16a. Deced	ent's Usual Occu kind of work done	oation during most of work d)	king	16b. Kind of Bus								
the Me	To Be Completed	Be	Be	Be	Be	Be	Be	ошо	Elementary/Secondary (0-12)	College (1-	4or 5+)		CRETARY	d)		SCHOOL	INGDALE SYSTEM
or other treumatic event, the M								17. Father's Name (First, Middle, L	ast)				18. Mother's Nem	e (First, Middle,	Maiden Sumeme	e)	
eumatic event, it								ToB	ToB	ToB							EVA MEFFERT
treum		19a. Informant's Name/Reletionsh  DARLENE HERRING		D			and Number or Rui										
other	-	20a. Method of Disposition		20b. F	Place of Dispos	sition (Name of natory or other pla	HIGHWAY,	Date		City or Town, Stata							
ury or		1 ☑ Buriai 2 ☐ Cremation 4 ☐ Donetlon 5 ☐ Other (Sp		erate		CEMETER'		1/22/99	E. FARMI	NGDALE, NY							
important: if item 27 is any injury or other tre ance.		21. Signeture of Funeral Service L	icensee Hada		Si			HWAB FUI	NERAL HO	ME, INC.							
		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that car	used the deat						Approximate Intervel Between							
g physicia as the bur	edlcai	edlcai	in/Medical Examiner	edicai	edicai		e. SUA b. Vens	eialor	F b./	Islan							
g physicia as the bur	w	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	a. CA		ORONA or as a consequence ISR de	on Dis	ery lis	Sedse,	Family	4)							
g physicia as the bur	w	that initiated events	0	tpue e	OROM or as a consequ	otas (	Diesse	HTN		tribute to the cause of							
g physicia as the bur	Physician/Me	that initiated events resulting in death) Last	0	tpue e	OROM or as a consequ	otas (	Diesse	HTN	tobacco uae con	tribute to the cause of							
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he Funeral Director: After this centificate has been signed by the attending physicial pletely filled in by the funeral director, page 2 should be datached for use as the but	To Be Completed by Physician/Me	25. Was case referred to medical examiner?  1 Yes 2 No  27. Menner of Death 1 Neutrel 5 Pending investigs 3 Suicide 6 Could not determine (Check only 2 Medical E	Hospital: 1 In In In In In In In In In In In In In	patient 2 Injury Day Year) If Injury - At h.g., etc. (Specific est of my knot is of examina	ISC July attention of the property of the prop	penca of):  Oderlying cause given as a polying	26. Place of Dea her: 4 Nursing Hirk? I Yes 2 No	23b. Did 1 24a. Was perfo	tobacco uae con Yes 2 No an autopsy med?  Yes No one) denca 6 Othe how injury occurre Street end Number wn, State)  cause(s) and med date and place, a	24b. Were autopsy fin available prior to completion of cau of death?  1 Yes 2N  or (Specify)  ed ar or Rural Route Number as stelled							
s centificate has been signed by the attanding physicia director, page 2 should be datached for use as the bur	edical Certification: To Be Completed by Physician/Me	25. Was case referred to medical examiner?  1 Yes 2 No  27. Menner of Death 1 Neturel 5 Pending investigs 3 Suicide 6 Could not determine (Check only one)  29b. Signature and title of certifier (Check only one)  30. Name and eddress of person we	Hospital: 1 In In In In In In In In In In In In In	patient 2 Injury Day Year) of Injury - At h.g., etc. (Specific Specific Spe	DROW or as a consequence ISC Julting In the un  ER/Outpatien 28b. Time of Injury ome, farm, stre y) wledge, deeth tition and/or Inv	penca of):  28c. Injunction  28c. Injunction  M 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	26. Place of Dea her: 4 Nursing Hirk? I Yes 2 No	23b. Did 1 24a. Was perfo	tobacco uae con Yes 2 No an autopsy med?  Yes No one) denca 6 Othe how injury occurre Street end Number wn, State)  cause(s) and med date and place, a	24b. Were autopsy fin available prior to completion of cau of death?  1 Yes 2N  or (Specify)  ed   ar or Rural Route Number or Rural Route Number on the cause(s)							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔍 🖣 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month CAMERON 1236 Am. HU SH 10 1999 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth GOOD SAMARITAN HOS PITAL BALTINUES BARTI MOE CITY Social Security Number If Under 1 Year | If Under 24 Hrs. Birthpiece (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Deys 1□M 2□F Yrs. 61 201-30-8580 11 - 22 - 37NC Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Locetion 10d. Inside City Limits MD XXYes 2□No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 908 Eveham Avenue 21212 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas Z ☑ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 X Never Merried 2 ☐ Married 1 ☐ Yes 2☐No Specify: Specify: Black 3 Widowed 4 Divorced Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Box U.S.A. Group, Elementery/Secondery (0-12) College (1-4or 5+) 10th Grade Inc. Laborer 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) Milton Cameron Lethia Cameron 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Margaret Fooks 908 Evesham Avenue Baltimor, Maryland 21212 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Burial 2 Cremetion 3 Removel from State
4 Doration 5 Other (Sec. 2011) 20c. Location - City or Town, State Voshell Mem.Gardens 01-16-99 Dundalk, MD 21. Signature of Funerel Service Licenses 22. Neme end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue Enter the disease, or complications that caused th, or heart failure. List only one cause on each line. ed the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, Approximete intervel Between Onset end Death immediete Cause (Finel MINUTES ARRHYTHMA disease or condition resulting In death) Due to (or es a consequence of): CORONARY METER DISERSE YEMES. Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings evalleble prior to completion of cause of deeth? 24a. Wes en autopsy performed? 1 ☐ Yes 250 No 1 Yes 2 No

**Physician** /Medical **Examiner** 

that the deeth certificate be executed

Box 68760.

P.0.

Records,

Division of Vital

The law requires

Hospital or Attanding Physician:

the th

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

Be

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Wedical Examiner naint be notified at

traumatic event,

permit. Pages 1 end 2 should be file Deportment of Health end Mental Hy Important: If Item 27 is marked other any injury or other traumatic event sonce.

should be filed within 72 hours effer on Mental Hygiene.

marked other than "natural", or ite

Baltimore, Maryland 21215-0020

with the Maryland

Examiner Physician/Medical þ Be Completed

1 Neturel

2 Accident

3 ☐ Sulcide

29e. Certifier

4 - Homicide

physician end the burial-transit ettending for use es signed by ate has pege 2 s director, Certification: To this funerel After s efter death. 5 filled in within 24 hours e To the Funeral D completely filled edical

27. Manner of Deeth

25. Was cese referred to medical 26. Plece of Death (Check only one) TOS Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28a. Dete of injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 5 Pending investigation

28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify)

MA

1 Yes 2 No 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

| Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the ceuse(s) end menner stated. 29b. Signature and title of certifie

6 Could not be determined

29c. License number 30950 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed ceuse of deeth (item 23e) (Type, Print) MONKTON

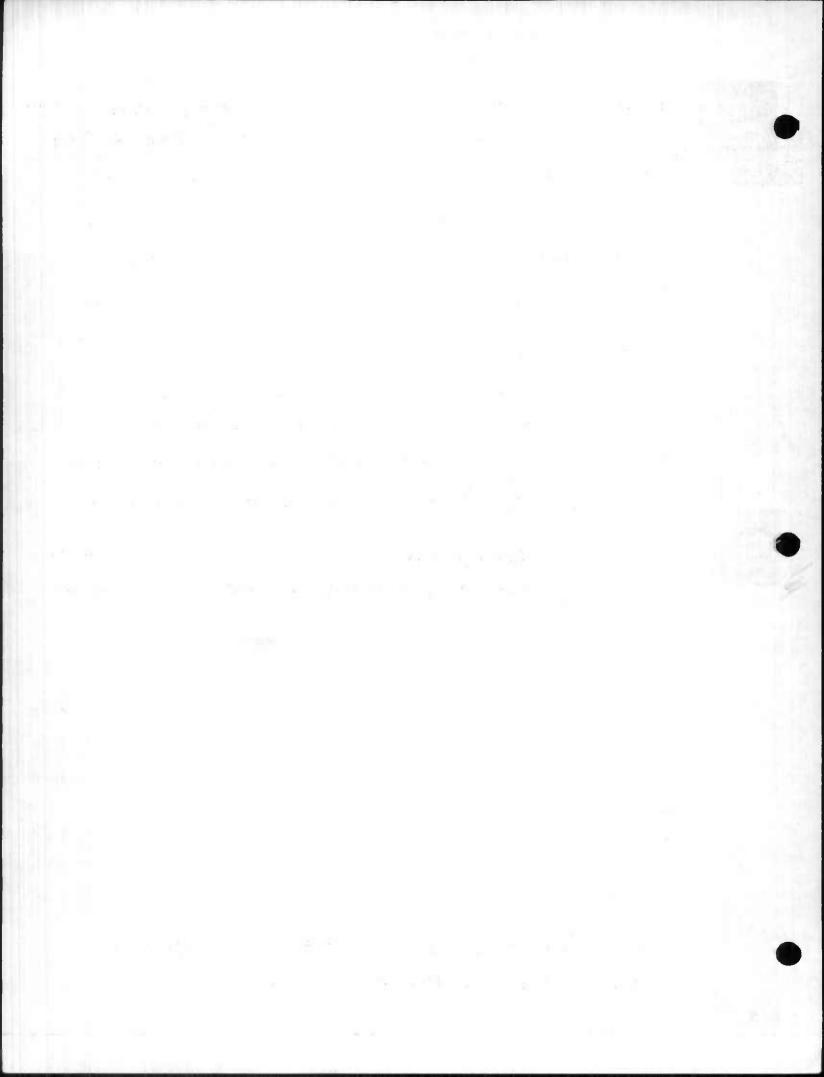
CHESTERFIELD 31. Dete filed (Month.

21111 MD.

State Registrar

9 1999

32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month **Physician** GIBSON JANUARY 1999 16-44 PM HEODORE 13 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPITAL MARBOR CENTER If Under 24 Hrs. 8. Date of Birth (Month, Dey, MAY 25 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Sacurity Number 9. Birthplaca (Stata or Foreign **Funeral** Days 129M 2□ F Months Hours 78 Yrs. MARYL AND 220-03-9988 Director Usual Residence of Decedant the Maryland 10c. City, Town or Location x 28a-f show a notified at 10d. Inside City Limits 10a. Stata 10b. County 1 ☐ Yes 20No Directo MARYLAND ANNE ARUNDEL BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 72 hours after death with "natural", or itema 23a or 21225 U.S.A. Funeral 210 MIDLAND AVENUE 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forcas? XX Yas 2 □ No ti Yas, Give Yaar or Datas: 43/47 Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 1 ☐ Navar Marriad 2 ☐ Married Specify: BLACK 1 ☐ Yas 2 ☑ Yo Specify: by 3 Novidowed 4 □ Divorced in then "nature Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) should be filed within 7: and Mentel Hygiene. Elementery/Secondary (0-12) Coilega (1-4or 5+) unknown MACHINIST BOSTON METAL CO 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Pages 1 and 2 should be named and Mentel JOHN GIBSON BESSIE GIESON 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Raiationship (Type, Print) 60 Health 3003 Oakhill Ave. Baltimore, Maryland 21207 Rosa Gibson-White/Daughter important: if its any injury or oth ance 20a. Method of Disposition 20b. Piaca of Disposition (Nama of camatary, cremetory or other placa) Data 20c. Location - City or Town, Stata Buriai 2 ☐ Cramation 3 ☐ Ramoval from State 1 - 19BALTIMORE NATIONAL BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) Signature of Funeral Service Licanse 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNEFAL FIOMF: PA 1206 W NORTH AVENUE ara 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarvai Batwean Onset and Death **Physician** /Medical Immediata Causa (Final RESPIRATORY FAILURE DAYS disaasa or condition resulting in daath) Examiner Dua to (or as a consaquance of): Examiner WEEKS ACUTE EXCACERBATION OF CHRONIC OBSTRUCTIVE executed physicien end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): PULMONARY DISEASE PNEUMONIA. WEEKS Box 68760 that the death certificate be Physician/Medical Dua to (or as e consequence of): for use es YEARG OR PULMONALE signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 0 PROSTATIC HYPERTROPHY 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, P 24b. Were autopsy findings available prior to should Completed 24e. Wes an autopsy performed? completion of cause of death? WE certificate has b 1 🗆 Yas 2 W No 1 ☐ Yes 2 ☐ No director, or Attending Physician: Be 25. Wes case rafarrad to medicat axaminar? 26. Pieca of Deeth (Chack only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yas 2 No this 28a. Data of Injury (Month, Day Year) funerai 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of After 1 Neturai 5 Panding ithin 24 hours efter death.

the Funeral Director: All

mpletely filled in by the fu death. 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be datarmined 3 Sulcide 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 4 Homicida Hospital 29a. Certifier 15 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical (Check only one) 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and placa, end due to the causa(s) and manner stated. within 2 To the alalst 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of cartifiar RESIDENT INTERNAL MEDICINE as 244 1614 A15 JANUARY 13th

S. HANOVER ST. BALTIMORE

MD 21225

3001

JAYACAKSHMI

State Registrar

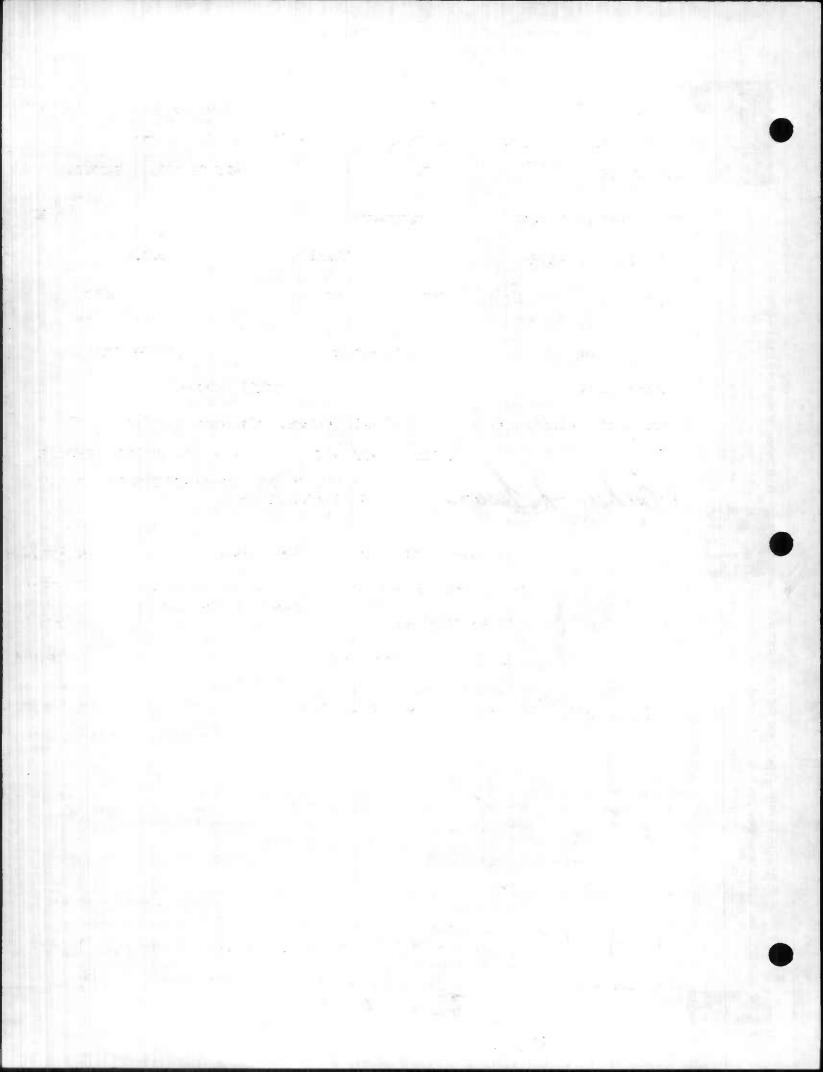
30. Name and addrass of person who complated cause of deeth (Item 23e) (Type, Print)

MN 1 0 1000

32. Regist

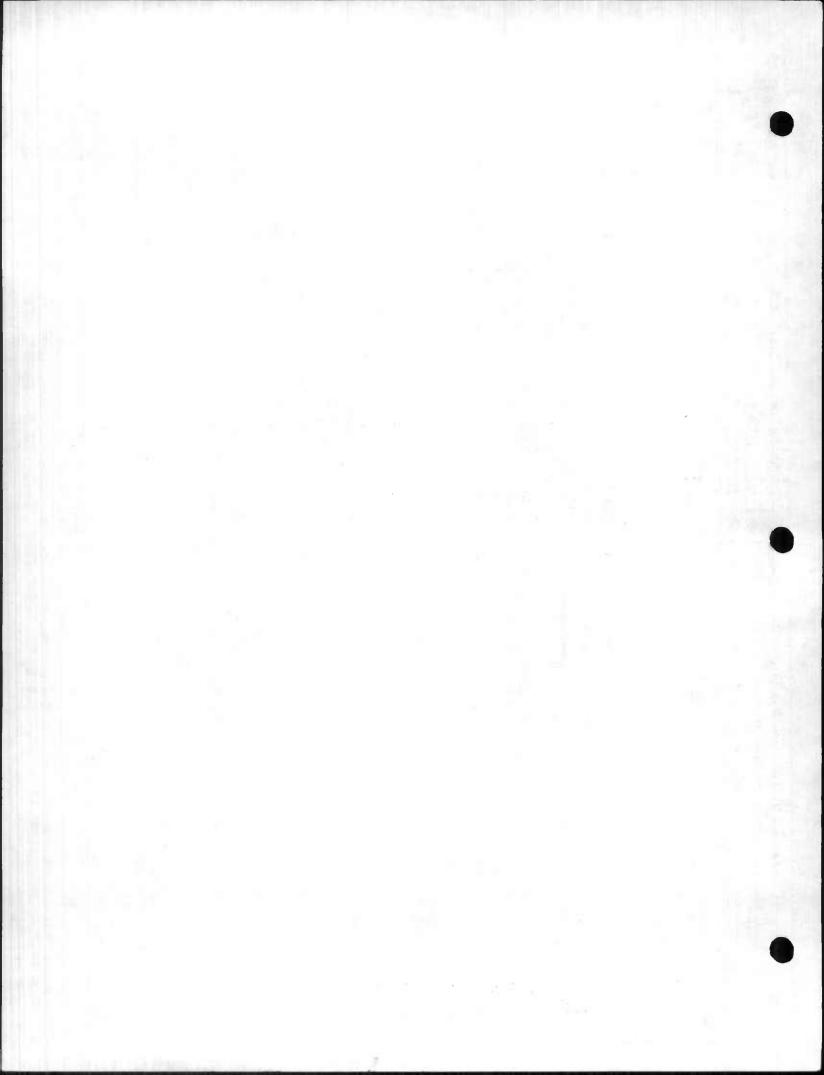
BALASUBRAMANIAN

31. Dete filed (Month, Dey, Year)



State of Maryland / Department of Health and Mental Hygiene 9 9 0 0 7 3 4

			Ce	rtificate of	Death		Reg. No.	00/34
Dhysisian	1. Decedent's Neme (First, Middle,		11/19		2. Date of De Month	ath Day	3. Time of Death	
Physician /Medical	PAULINE MAYBELL			GUARALDO			13,199	
Examiner	4e Facility Name (If not institution,	4b. City, Town, or Le			n, or Location of Deat	4c. County	of Death	
Det	Crofton Convale				CROF			ARUNDEL
Funeral Director	5. Social Security Number  139-05-7285  Usual Residence of Decedent	6. Sex 1□ M 2XF 7. Age (In yr 84	s. last birthday Yrs.	If Under 1 Year   Months   Days	If Under 2	Min.  8. Date of Bir (Month, De NOV • 7		9. Birthplace (State or Foreign Country) Pennsylvania
how an	10a. Stete 10b. County	10c. (	City, Town or L	ocation				10d. Inside City Limits
Ma set and oto	MD Anne A	rundel	Croft	on				1□ Yes 2只No
th with the Mary 23e or 28e-f sh wat be notified.	10e. Street and Number 2131 Davidsonvi	lle Road		10g. Citizen of What Country? USA				
020 ors after des elf., or flems Examiner, m	11. Meritel Stetus  1 Never Merried 2 Marrie 3 XWidowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? d 1 Yes 2 No if Yes, Give Yeer or Detes:	U,S. 13.	13. Wes Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto F				- American Indian, C, White, etc. White
21215-0 ad within 72 ho agiliere. er than "natur t, the Medical.	15. Decedent's (Specify only highest			dent's Usuel Occup kind of work done		of working	16b. Kind of Bu	siness/Industry
The state of the s	Elementery/Secondery (0-12)	College (1-4or 5+)	lite.	DO NOT use retire	d)			
d 2	12		Owne	r/Operato			Groce	-
Be every	17. Father's Name (First, Middle, Li					s Neme (First, Middle		)
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Mar 2 sh 1 and 1 mm	19e. Informant's Neme/Reletionshi					or Rural Route Numb		
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Pages Sent of H	20e. Method of Disposition 1 → Burial 2 □ Cremetion 3		cemetery, cre	osition (Neme of metory or other ple	ce)	Dete	20c. Location - (	City or Town, Stata
altim artimen ortant: injury	4 Donetion 5 □Other (Spe	ecify) Ho	oly Cro	ss Cemete	ery	01/19	Delawar	e County, PA
Baltimore, permit. Pages 1 as Department of Hea Important if Item any Injury or other store.	21. Signeture of Funeral Service U	A about 1	C E		FUNE	RAL HOME RD GAMB		ID 21054
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/Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth)	a Coronory	arlin	v du	ore			2 serari
	Tosulaing in Geetin)	Due	(or as e conse	quence of):				(/
June of		b			100			
death certificate be executed death certificate be executed attending physician and ad for use as the burial-transit sician/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	(or as e conse	quence of):				
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Is, P.O. Box es that the death ce igned by the attendi be detached for use by Physiclan/I	Part II. Other significant condition	s contributing to death but not re	esulting in the I	underlying cause gi	ven in Pert I.		1	tribute to the cause of death?
E X 70	Cereto Ulycul	in Headint				10	Yes 20No	3 Probably 4 Unknown
Records, P.O. he law requires that the a has been signed by th age 2 should be defach ompleted by Phys							an autopsy	24b. Were autopsy findings available prior to
D 8 8 8								completion of cause of death?
= F 5 0						10	Yes 2 DAYO	1 Yes 2 No
Vital I	25. Was case referred to medical examiner?	Mossiteli		low	- 4	of Deeth (Check only	one)	
To To	1 Yes 2 No		☐ ER/Outpatie	N 3LI DOA		sing Home 5 Resi		. , ,,
Division of standing P is after death.  In Director: After ted in by the funer.  Certification:	27. Mennes of Death  1 Neturei 5 Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time o	Wo			how injury occurr	ed
Division of a standing P after death. Director: After din by the funer ertification:	2 Accident investige			M 1	Yes 2□N			
Division of Attendant after death I Director: d in by the Sertificat	3 Suicide 6 Could no 4 Homicide determin	ed 28e. Piece of Injury - At building, etc. (Spec	home, ferm, st	reet, fectory, office		28f. Location ( City or To		er or Rural Route Number,
C led on a								
Divi	29a, Certifier (Check only one) Certifying 2 Medical Expone)	Physician: To the best of my kaminer: On the basis of examiner end menner steted.	nowledge, deet netion and/or Ir	th occurred at the til ivestigetion, in my o	me, date and opinion, deeth	place, end due to the occurred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
To the comp comp	29b. Signeture and IIIIe of certifie			29c. Licens	se number		29d. Date signed	(Month, Day, Year)
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(1)	30. Name and address of parson wi	no completed cause of death /Iti	em 23a) (Tvre	Print)	4		-	111
	Daleet Sing	Lo Fichen 14	13 Ann	wholes	Road	#106 O	denton	MD 211/3
State Registrar	31. Date Ned (Month, Dey, Yeak) ) IAN 19199	32. Registrer's Sig	G. A	on Kil				



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 11, 1999 TIMOTHY GEE 1:42 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 24 Hrs. 8. Date of Birth November 23, 1956 If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 10XM 2□ F Deys Hours Min 42 Yrs. Baltimore, Maryland 220-66-0657 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours efter death with the Maryle nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-1 show ury or other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Co. Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 H Quiet Stream Court 21093 United States of America Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1∜D Yes 2 □ No tf Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status Biack, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: Asian þ 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) AAI Coilege (1-4or 5+) Shipping Clerk Engineering/Designing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert Gee 2 Lien K.Chung 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. David Gee (Brother) 1356 Savannah Court Hampstead, Maryland 21074 20a. Method of Disposition 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State permit. Page Department of Important: If any Injury or 4 □ Donation 5 Mother (Specify) Entombment Prraine Park Mausoleum 1/18/99 Woodlawn, Maryland 21. Signature of Funera) Service Licenses 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset end Deeth **Physician** INTRACEREBRAL BLEED 3 DAYS /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner attending physician and for use as the bunel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): P.O. Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 88 esn ed by the a Part II. Other etgnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes ZETNo 3 Probably 4 Unknown signed t Records, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of ceuse of death? page 2 has 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital or Attending Physician: funeral director, Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA After this 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 A Natural 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: Af investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital the Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signeture and title of 29c. License number 29d. Date signed (Month, Day, Year) D24034

30. Name and address of person who completed ceuse of death (item 23a) (Type, Print)

1999

7620 YORK ROAD,

32. Registar's Signature

TOWSON, MARYLAND 21204

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M. D. ,

TIMOTHY LOW,

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Registrar

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State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Katherine Mary Grail 16,1999 January 2:25p.m. /Medical 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 329 Sturtons Lane If Undar 1 Yaar | If Under 24 Hrs. Hours | Min. Pasadena Anne Arundel Co. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Days 1□ M 2⊠ F 214-12-4759 Yrs Director 78 June 15,1920 Maryland Usual Residence of Decedent I 2 should be filed within 72 hours effer death with the Menyland nend Mental Hydiene.
Is marked other than "natural", or fleme 23a or 28a-1 show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits th end Mental Hygiene. 7 is marked other than "natural", or flama 23a or 28a-f ahov treumstic event, the Medical Examiner must be nothed at Maryland Anne Arundel Pasadena 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 329 Sturtons Lane 21122 U.S.A. Funeral 12. Was Decedant Evar In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Datas: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 10 N/AHomemaker Own Home 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Harry Koontz Edith White 2 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 Department of Heelth e Important: If Item 27 Is any Injury or other trea Cynthia Jacobs Daughter 329 Sturtons Lane Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Neme of Date 20c. Location - City or Town, State Cedar Hill Cemetery Jan. 21,1999 Baltimore, Maryland 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licenses 22. Name and Addrass of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final Fliablastoma disease or condition resulting in death) Examiner Due to (or as e consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours effer death.

24 hours effer death.

24 hours affer death.

25 hours affer this certificate has been signed by the attending physician and been signed by the attending physician and seley filled in by the funeral director, page 2 should be deteched for use as the buriat-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury thal initiated events resulting In death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to complation of cause of death? 24e. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) Certification: 27. Manner of Deetl 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Streat end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital c within 24 hours of To the Funeral D completely filled edicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifian 29d. Data signad (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n.0-

State Registrar

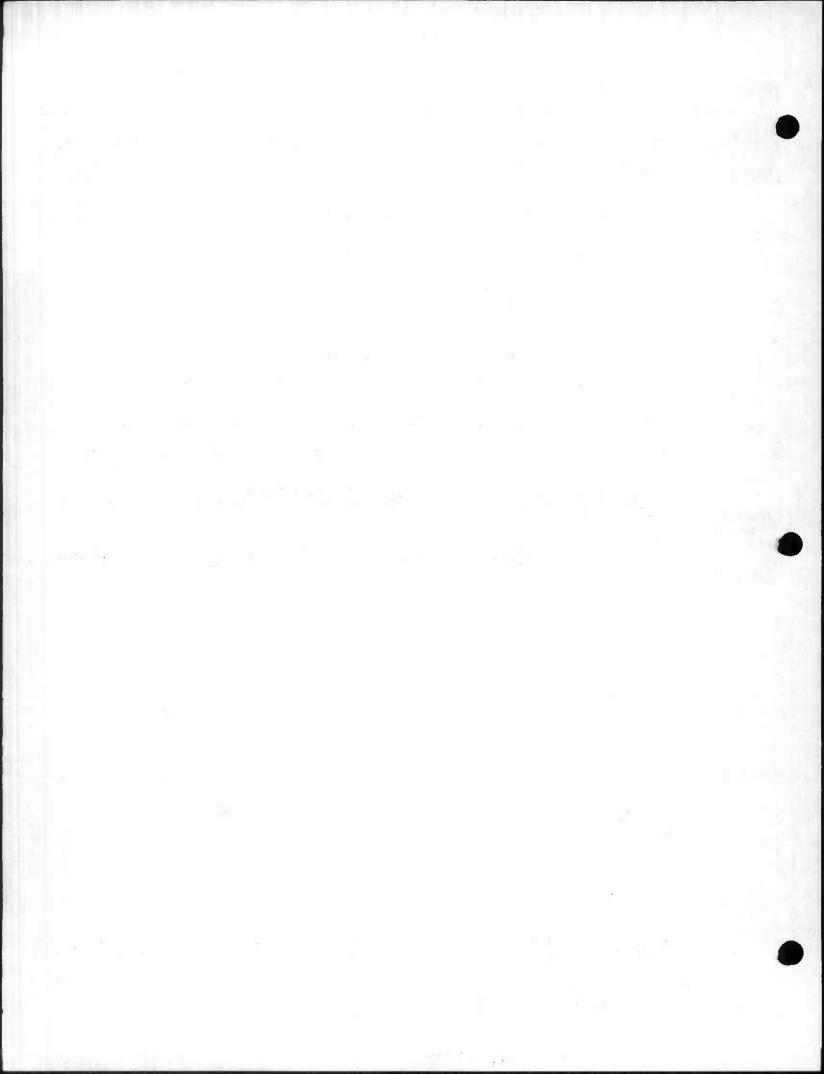
31. Date filed (Month.

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Baltimore, Maryland 21215-0020

Box 68760.

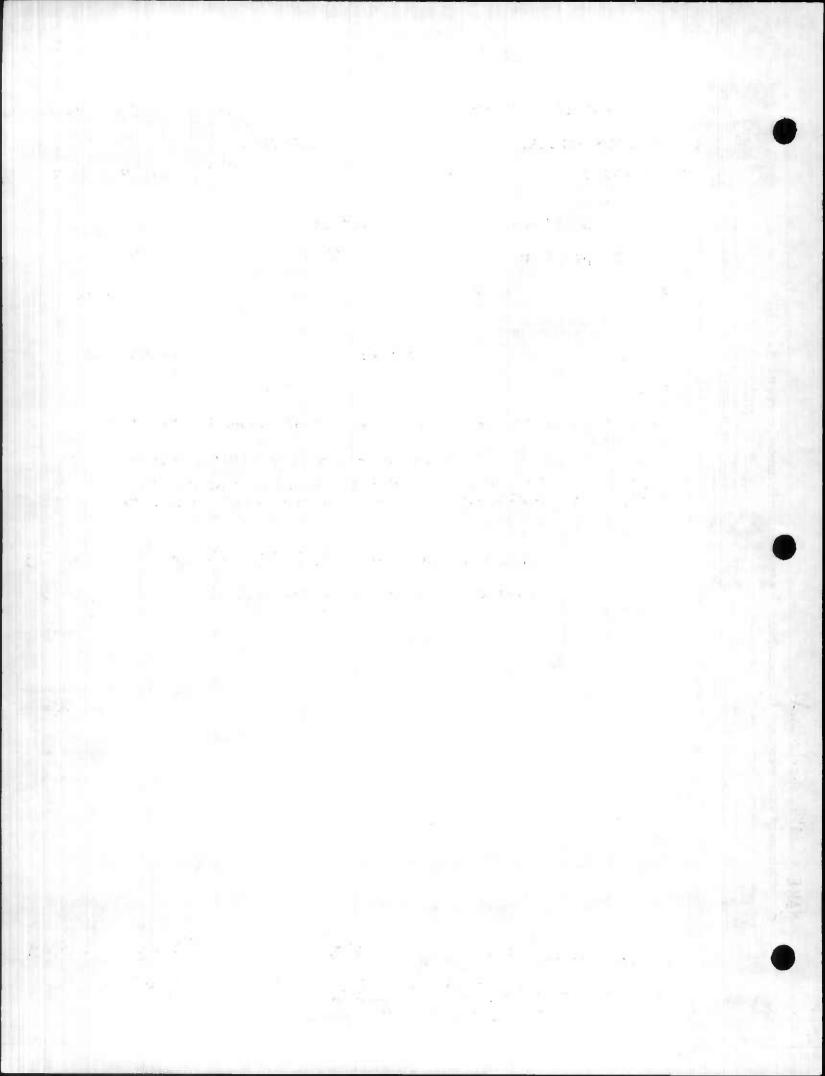
Division of Vital Records, P.O.



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Date of Deeth Day **Physician** Robert M. Gross JANUARY 9, 1999 1917 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner ST AGNES HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) DEC 31, 19 9. Birthplace (State or Foreign Country)
New York 5. Sociei Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 10XM 2□ F Yrs. 089-30-7227 61 Director Usuel Residence of Decedent the Maryland r 28a-f show 10e State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo Director Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be r 407 Trappe Road 21222 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Insert of Health and Mental Hygiene.
Insert Fauracke other than "natural", or flome 23.
Iny or other traumatic event, the Medical Examinal man. Funeral 14. Reca - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marltai Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes: 1X Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Printer Print Shop 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) UNK. UNK. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Anita Alexander/Friend 407 Trappe Road Dundalk, MD 21222 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any Injury or Metro Crematory, Inc. 01/16/99 Baltimore, MD 4 Donetion 5 ☐ Other (Specify) 21. Signeture Cremation Society of MD, Inc. Edward A. Gregorchik Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting In deeth) myararo Examiner Due to (or as e consequence of) Physician/Medical Examiner 00000 OC Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or eş a)consequence of): Division of Vital Records, P.O. Box 68760 Due to (or es a consequenca of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an eutopsy page 2 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient ≥ ER/Outpetient 3□ DOA 9 28e. Dete of tnjury (Month, Dey Year) 28c. tnjury at Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 1 Neturei 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident l or Attank after deat Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of tnjury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 24 hours Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) To the within 2 To the 29d. Date signed (Month. Dev. Year) 29 Signeture and title of certifier 29c. License number ne end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 30 ton Avenue Baltimore 0 31. Date filed (Month, Day, Year) State JA: 19 Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2 Dete of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 00 Month 18 1959 TANUATRY 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street end number, 9109 Bronze Bell Circle Columbia Howard 8. Dete of Birth (Months Day, Year) If Under 1 Yeer If Under 24 Hrs. Birthplece (State or Foreign Country) New York Sex 1₽M 2□F 5. Sociel Security Number 7. Age (In yrs. last birthdey) Deys Hours Min. 084-14-9769 81 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Howard Columbia 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 9109 Bronze Bell Circle 21045 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Detes: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 XNo Specify: Specify. 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Clerk-Typist State Government 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Julius Gordon Tillie Rothstein 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Cowles/Daughter 9109 Bronze Bell Circle Columbia, Maryland 21045 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 1-19-99 Catonsville, MD 22. Name and Address of Feellity Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last proscle Due to (or es e consequence of) Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yas No 3 Probably 4 Unknown multi Infanct demente 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24e. Was an autopsy performed? 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of

**Physician** /Medical Examiner

Examiner

Physician/Medical

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Completed

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Physician

/Medical

Examiner

**Funeral** 

**Director** 

ir than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at

I Hygiena.

permit, Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: if Nem 27 is marked other tt any Injury or other traumatic event, the once.

Directo

Funeral

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Completed

the Maryland

deeth .

altimore, Maryland 21215-0020

USB detached page 2 s 388

funeral

After this within 24 hours after death. To the Funeral Director: A 3 completely 25 0

P.O. Box 68760, Division of Vital Records, or Attending Hospital

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 1 Netural
2 Accident 5 Pending investigation 1 □ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and menner es steted.

2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

29b. Signature and title of certifie

JANUarey 18, 1999.

29d. Dete signed (Month, Dey, Year)

30. Neme end eddress of person who completed car of death (Item 23a) (Type, Print)

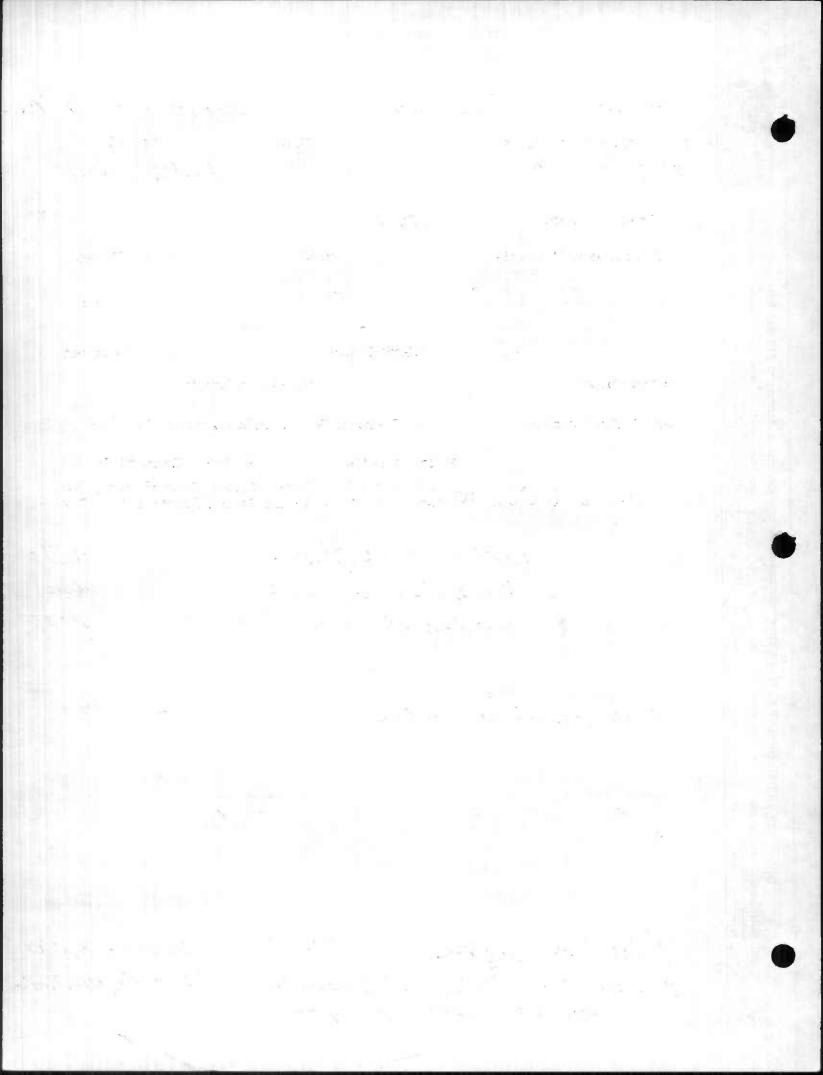
31. Date filed (Month, Dey, Year) JAN

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**DHMH 16 Rev 6/95** 

Registrar



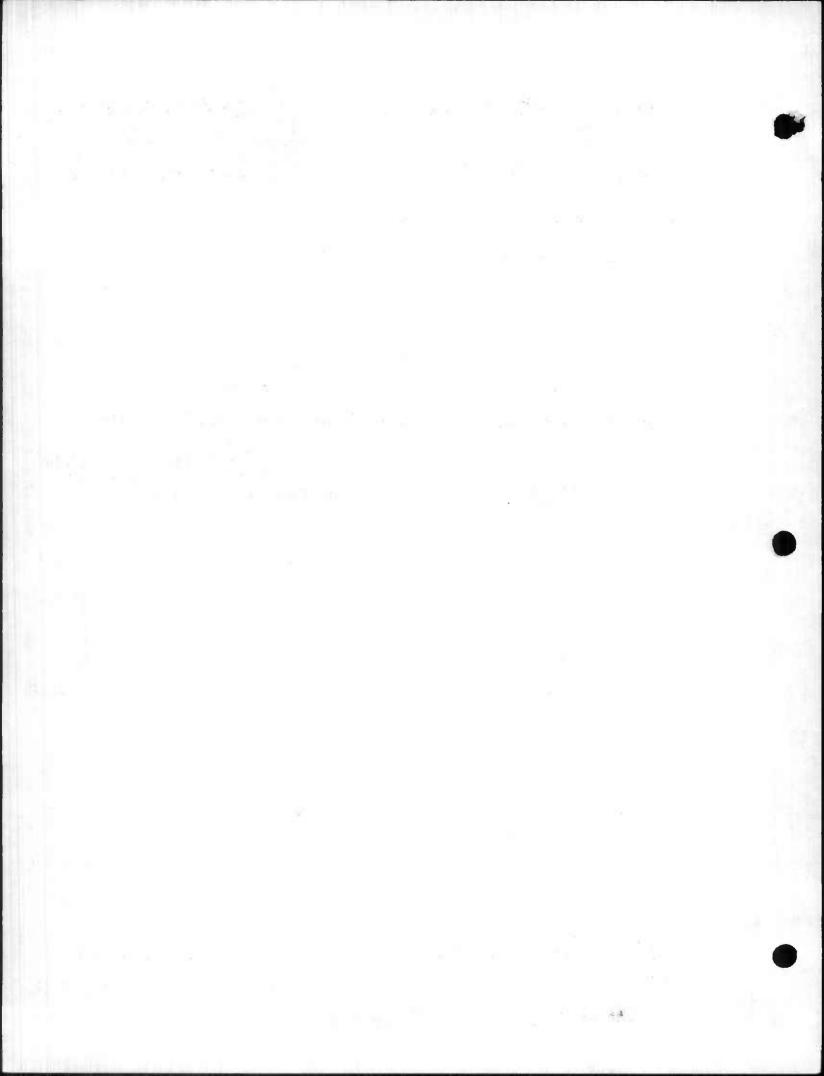
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death Reg. No.

1. Decedent's Nema (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month JANU4124 Grane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Vantage House Columbia Howard If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number If Under 1 Yaar 9. Birthplace (Stata or Foreign Country) New York 7. Aga (In yrs. last birthdey) **Funeral** Deys 1 M 2 F Yrs Director 057-05-2127 Usual Residence of Decedant 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryla 7 is marked other than "natural", or items 23s or 28e-f show traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Columbia Director Howard 10g. Citizan of What Country? 10e. Street and Number 10f. Zlp Coda 21044 U.S.A. 5400 Vantage Point Road H403 Funeral 12. Wes Decedent Evar in U,S. Armed Forcae? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after 0 begunnent of Health and Mental Hygiene. Introcreated it the marked other than "natural", or then any injury or other traumatic event, the Medical Examines obse. Bieck, Whita, etc. White I ☐ Yas 2;☐No If Yes, Give Yaar or Detes: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Stephen O'Connor Mary Howard 0 19e. informent's Nema/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 320 Broad Creek Drive, Annapolis, MD 21401 Stephen H. Greene (Son) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 □ Cramation 3 □ Ramoval from Stete 1/26/99 Arlington, Virginia Arlington National 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Feellity Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, Maryland 21045 Kenmer 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Batween Onset and Death Physician /Medical Immediete Cause (Final diseese or condition resulting in deeth) Examiner Examiner 15cas attending physician and for use as the burial-transit Sequantielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated avents resulting in deeth) Last Box 68760. Physician/Medical Dua to (or as a consequence of) 88 Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. Division of Vital Records, P.O. the 23b. Did tobacco use contribute to the cause of death? signed by t 1 Y88 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peed : has certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifice 25. Wes case referred to medical axaminer? 28. Place of Deeth (Check only one) Other: Nursing Home 5 Reeldence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No invastigetion 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicide 11 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end manner as steted.
2 Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, deeth occurred et the time, dete and piece, and due to the cause(s) end manner steted. 29e. Certifian Medical (Check only one) 29b. Signeture end titla of certifier 29d. Data signed (Month, Day, Year) 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) Flower 11055 mo 31. Dete filed (Month, Dey, Year) 32, Registrer's Signeture

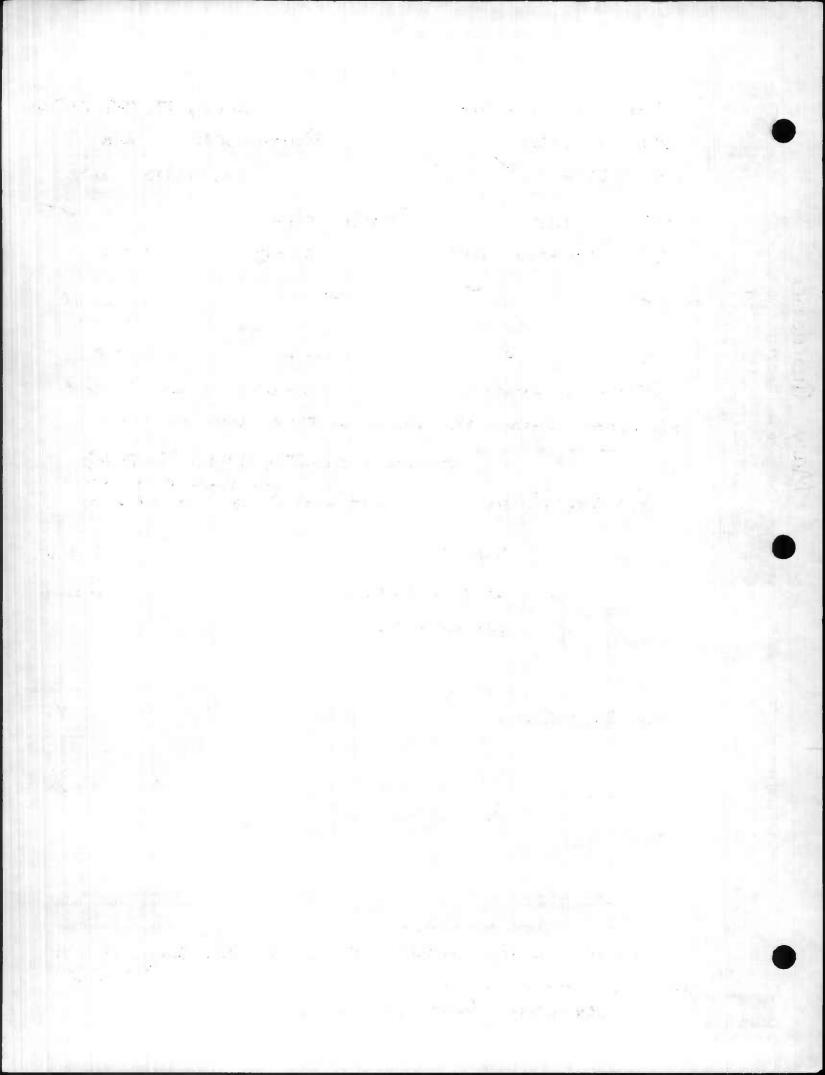
State Registrar

JAN 1 9 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** (FIDRDAND · A. January 1:08 am MARY /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Hospital NIA Sinai If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) Deys 1 M 201 129 - 16-3972 Usuel Residence of Decedent Yrs. Director with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic avent, the Medical Examiner must be notified at 1 Tes 2 No MD Director NIA ALTO. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code HAY WARD 3711 U.S.A Funeral 14. Race - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours efter ment of Health and Mental Hygiene. ant: if item 27 is merked other than "natural; or the ury or other traumatic avent, II a Medical Examine ury or other traumatic avent, III a Medical Examine. 1 ☐ Yes 2 ☐ No if Yes, Give Yeer or Detes: Giordano 1 Never Married 2 Married 1 ☐ Yes 2 DNO Specify: WHITE by 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working iife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Housewife Home +4 NIA 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be -elice ARDUIN1 LENTRICHM VINCEN331A 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stefe, Zip Code) BALTO MD -RO GIDRDAND, SR 845 GrADHOIST MR Thomas 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete Important: If it any injury or o 1 Burial 2 Eremation 3 Removel from State Greenmount crematory 1/19/99 BALTO. MI 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility HARTLEY Miller Funeral Home 23a. Pent. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. BALD. Approximete Intervet Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting In deeth) Meastal Examiner Due to (or es e consequence of) Examiner divertiwlitis physician and the buriel-transit the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760. pheumonia Physician/Medical 88 ettending for use as signed by the e Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown hypothyroidism ģ 24b. Were autopsy findings aveilable prior to Completed 24e. Wes en autopsy performed? completion of cause of death? is certificate has be 2 NO i or Attanding Physician: after death. Director: After this certifica 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) To Hospitat: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA funeral 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Certification: 1 Neturel
2 Accident 5 Pending 1 🗆 Yes 2 No Investigetion 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours after To the Funeral Director Completely filled in 1 Cartifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certitier Medical 29b. Signeture and title of cartifier Internal Medicine Resident 29c. License number 29d. Dete signed (Month, Day, Year) AS2402321-9493 Erondu, MDAD January 17, 1999 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Baltimore, Maryland Sinai Hospital. 21215 2401 West Belvedere Avenue Ugochi Erondu, MDPhD, 32. Register's Signeture JAN 1 9 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Yeer Paul Goldsmith 16, 1999 4c. County of Deeth 11:40 AM January /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth Examiner Rockville er If Under 24 Hrs. Shady Grove Adventist Hospital MD Montgomery If Under 1 Yeer 5. Sociei Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** XXM 2□F Deys Hours Yrs. Director 85 July 12, 1913 Germany Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5313 Gleenwood Road Funeral USA 14. Race - American Indian, Bleck, White, etc. death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status Pages 1 and 2 should be filed within 72 hours effer in ant of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2€ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes Z No Specify: by Specify 3€XWidowed 4 □ Divorced White Completed 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) 12 Salesman Restaurant Supply 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Ferdinand Goldschmidt Lina Strauss 19e. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 is Department of Health er Important: if item 27 is any injury or other trau once. Howard Burger/Son-in-Law 5313 Gleenwood Road, Bethesda, Maryland 20814 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) VICA 20a. Method of Disposition Date 20c. Location - City or Town, Stete VICN 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) South Bend, Indiana 22. Name end Address of Fecility Ives Pearson Funeral Homes 2847 Wilson Blvd., Arlington, Virginia

The disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Applicant fellure. List only one cause on each line. 22201 Approximate Interval Between Onset end Deeth **Physician** /Medical immediete Ceuse (Finel MOUNT disease or condition resulting in deeth) Examiner Examiner physiclen end the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest P.O. Box 68760. Physician/Medicai Due to (or es e consequence of) been signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 Tyee 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings aveileble prior to completion of cause of death? Be Completed 24e. Wes an autopsy performed? page 2 s 1 Yes certificate Division of Vital tal or Attending Physician: The safter death.

al Director: After this certificate of in by the funeral director, pa 25. Wes case referred to medical 26. Piece of Deeth (Check only one) exeminer Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 1 ☐ inpatient 2 ☑ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Maturei 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral DI completely filled in Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end plece, end due to the cause(s) end menner steted. edicai 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print) Medical Center Drive Rockville MD 20150 Thai 9901 Martin McGretuy

State Registrar 31, Dete filed (Month, Dev. Year) JAN 1 9 1999 32. Registrer's Signeture

WRC 99-0106-510 **ELIZABETH** 

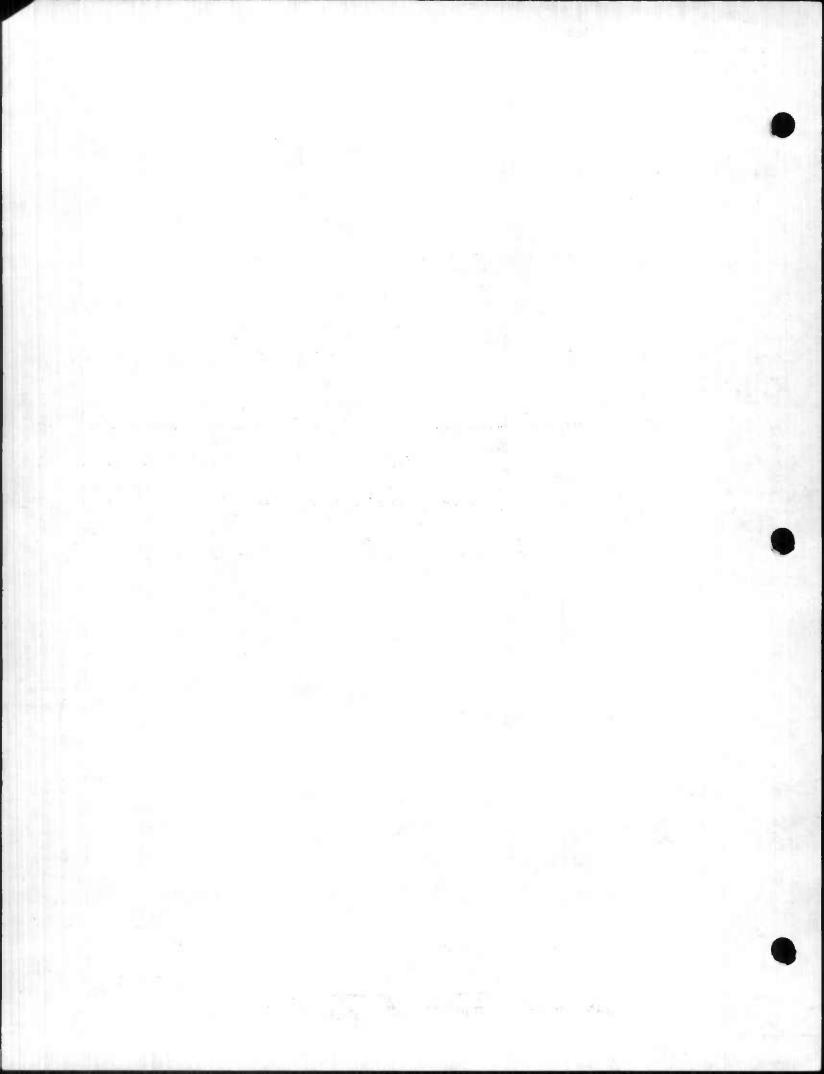
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State of Maryland / Department of Health and Mental Hygiene (

GAINES			Certifica	te of Death	Rec	g. No.	7 1 100			
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/Medical Examiner	4a Facility Neme (If not institution, give s 5 N. CATHERINE	treet and number)		4b. City, Town, o	Location of Death	4c. County of Deeth	10			
Funeral	5. Social Security Number 6. Sex			er t Year   If Under 24 Hr	s. 8. Date of Birth	9. Birth	nplace (State or Foreign			
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M its	20e. Method of Disposition  1 Burial 2 Cremetion 3 Re	emovel from State	cemetery, crematory of	other place)						
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permit. Ps Department Important: any fnjury once.	21. Signetativ of Funeral Service Literatuse	· (2)	22. Name	And Address of Facility BI	ROUNJ	R. FUNER	2AL HOME			
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Physician: this certific ral director,	avaminar?	ospitel:	☐ ER/Outpatient 3☐ [	Other		nce 6 Other (Spec	eify)			
g Physical dispersion: To	27. Menner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	v injury occurred				
Attanding I r death. ector: After by the funer iffication	1 Neturel 5 Pending investigation	(Motter, Day Four)	M	1 ☐ Yes 2 ☐ No						
To the Hospital or Attanding Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	28f. Location (Street and Number or Rural Routa Number, City or Town, State)							
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he Hospit in 24 hour he Funeri pletely fill edical	29a. Certifier (Check only one) Certifying Physical Examin	er: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and place, in my opinion, death occ	ce, and due to the car curred et the time, dat	ise(s) and manner as ie end place, and due	to the cause(s)			
To the Hospital within 24 hours To the Funeral completely filled	29b. Signature and title of certifier	and mannor stated.	2	9c. License number	29	d. Date signed (Month	n, Day, Year)			
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,	30. Nama and address of persoa who cor	npleted cause of death (Ite	m 23a) (Tuno Print)	O.C.PI. E	. 02	TIONAL OUT	-111			
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DHMH 16 Ray 6/95

State Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Gettman **Ethel** Naomi January 1999 8:25 PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Mariner Health of Forest Hill Forest Hill Harford If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 28 F Months Days Hours 86 Yrs Director 217-76-2334 -15-12 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 25a-f show anotified at show 1 Yes 2 □ No Director BEL AIR MD HARFORD 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 8 event, the Medical Examiner must be harns 23a FRANCIS ROAD Funerai 21014 12. Was Decedent Ever in U,S.
Armed Forces
1 Yes 2 No
If Yes, Give
Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within Hygiene. Wher than Etementary/Secondary (0-12) Coilege (1-4or 5+) 12 NA SELF EMPLOYED CONVENIENCE STORE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) h and Mental I CHARLES COOKEY SALLIE WATSON 19a. Informant's Name/Retetionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is any Injury or other trau 1217 ST. FRANCIS RD. BALTO, MD 2/014
ce of Disposition (Neme of Dete 20c. Location - City or Town, State PATRICIA MASON (DAUGHTER) 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State MORELAND MEM. PARK CEM. 1-19-99 BALTIMORE, MD

22. Name and Address of Facility

BALTIMORES, MD. 21214 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 23a. Part. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? by the 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed d be de þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? peen page 2 certificate R No Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certification physicial director, it is funeral director. 25. Was case referred to medicat exeminer?
1 ☐ Yes 2 No Be 28. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28e. Dete of tnjury (Month, Dev Yeer) 28c. tnjury at Work? 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

CIS W. MACPHAIL

9 1999 Registrar's Signeture

State

Registrar

31. Date filed (Month, Day

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth HOLLAND Month Des Year MARIE IMELDA JANVARY 8:05 PM 12 1999 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) HOSPITAL (ENTER BALTIMORE HARBOR If Under 1 Year 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Months Deys Hours 1 M 2 TF 216-32-6526 Usuel Residence of Decedent MARCH 11,1937 MARYLAND 10d. Inside City Limits 10e. State 10b. County 10c. City, Town or Location ▼□ Yes 2□ No MARYLAND N/A BALTIMORE 10f. Zip Code 10a, Citizen of Whet Country? 10e. Street end Number 2038 DEERING AVENUE 21230 J.S.A. 14. Raca - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorcad WHITE 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ELECTRONIC SCHOOL UNK SECRETARY 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) JAMES ROBINSON AGNES GALLAGHER 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) TIMOTHY C. HOLLAND (SON) 528 SALTOUN AVENUE - ODENTON, MARYLAND 21113 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1/16/99 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) LAUREL, MARYLAND BALTO/WASHINGTON CREMATORY 22. Name end Address of Fecility HUBBARD FUNERAL HOME, INC. 21. Signature of Funeral Service Licansee 23a Parti Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, show, or heart failure. List only one cause on each line. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 Approximete Interval Between Onset and Death Immediate Ceuse (Finel BACTEREMIA disease or condition resulting in death) WOOK Due to (or as e consequence of): PNEUMONIA MONTH Due to (or as e consequenca of) BLEED Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown OBSTRUCTIVE PULMONARY DISFASE 24b. Were autopsy findings evalleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed' 1 Yes 25 No 1 Yes 2 No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner Examiner physician and s the bunal-transit that the death certificate be executed Physician/Medicai

signed by the a

is certificate has t director, page 2 s

funeral

Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu

by

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Certification:

edical

**Physician** 

/Medical

**Examiner** 

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**Funeral** 

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r than "natural", or items 23s or the Medical Examinar must be r

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filled within

Hygiene.

Pages 1 and 2 should be fill ment of Health and Mental H tant; If item 27 is marked oth jury or other traumatic even

Department of Important: If it any injury or o

Baltimore, Maryland 21215-0020

Box 68760

Records,

Division of Vital

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest

examiner? 1 Yes 2 No 27. Menner of Deeth

28e. Dete of Injury (Month, Dey Year) 5 Pending Investigation

28b. Time of Injury

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29e. Certifier

1 Neturel

2 Accident 3 Suicide

4 | Homicide

Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

29c. License number

29b. Signeture end title of certifier

tu

6 Could not be determined

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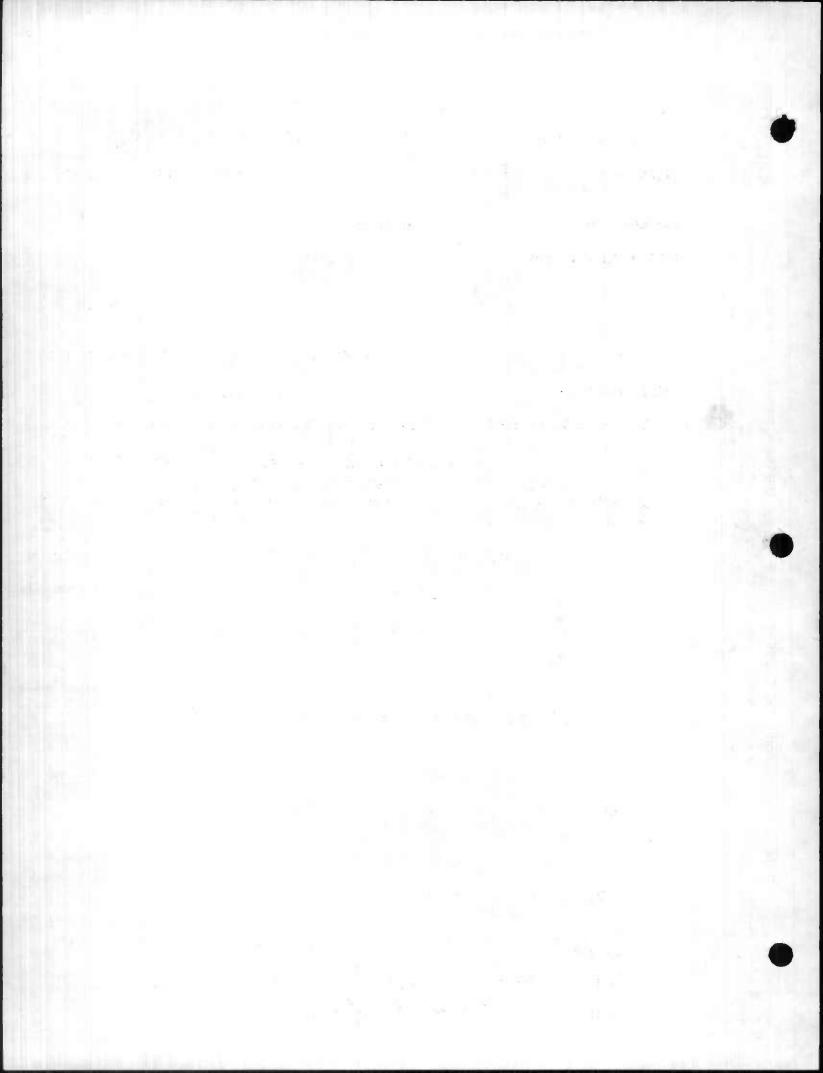
29d. Dete signed (Month. Dav. Year) TANUARY 12

30. Name end eddress of person who completed cause of deeth (Item 23e) (Typa, Print) ATPL

VSH 31. Dete filed (Month, Dev. Year)

HARBOR 32. Registrer's Signature

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First Middle Last) 3. Time of Death Month **Physician** 1:30pm Martha 13, Μ. 99 Jan. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, giva street and number) Examiner NΔ Baltimore 3000 Seabury Road If Undar 1 Yaar | If Undar 24 Hrs. Birthplaca (Stata or Foreign Country)
 NC 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth **Funeral** 1□M 2K F Months Days Hours Min 243-60-7773 Yrs. 04-04-11 Director Usual Rasidence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Health end Mentel Hyglens.

In this file 27 is marked other than "natural", or itams 23s or 28s-1 show mix; if then 27 is marked other than "natural", or other traumatic event, the Medical Experiment man be notified at my or other traumatic event, the Medical Experiment man be notified at r 28a-f ahow 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits Mas 2□No Directo NA Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ir than "natural", or itams 23s or Apt. "B" 21225 USa 3000 Seabury Road Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or Notif Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - Amarican Indian, Biack, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: Black à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Rusiness/Industry Co. Elamantary/Secondary (0-12) Collega (1-4or 5+) 10th Grade Carr Lowery Glass Laborer 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Bay Unknown 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 21225 19a. Informant's Name/Ralationship (Type, Print) 3000 Seabury Road Baltimore, Maryland Pauline Holt 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, Stata X Buriai 2 Cramation 3 Ramoval from Stata Department o important: if i any injury or Cedar Hill Cem. 01-19-99 Anne Arundel Co, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WD.C.March FH 1101 E. North Avenue Part. Embride Unleaded to compare the state caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medicai Immediata Causa (Final diseasa or condition resulting in death) 8 years Coronary Artery Disease Examiner Dua to (or as a consequence of): Examiner 8 years Essential Hypertension physician and s the buriel-transit the death certificate be executed Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): 3 years Pernicious Anemia Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of): ettending ph for use as t 6 years Hypothyroidism signed by the e 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of causa of death? paga 2 s has cartificate 1 Yes 25 No Hospital or Attanding Physician: 24 hours after death. Funeral Diractor: After this certifics funeral director, 25. Was case referred to medical examiner? 26. Piace of Death (Check only one) Othar: 4 Nursing Home 5 X Residence 8 Othar (Spacify) 0 1 ☐ Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mennar of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 5 Panding investigation 1 Naturei 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 1 Cartifying Physician: To the best of my knowledga, death occurred at tha time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifian Medical 29b. Signature and title of certified 29d. Data signed (Month, Day, Year) 29c. Licansa number 01/15/99 D14160

M.D. 5410-A Ritchie Highway Baltimore, Md. 21225

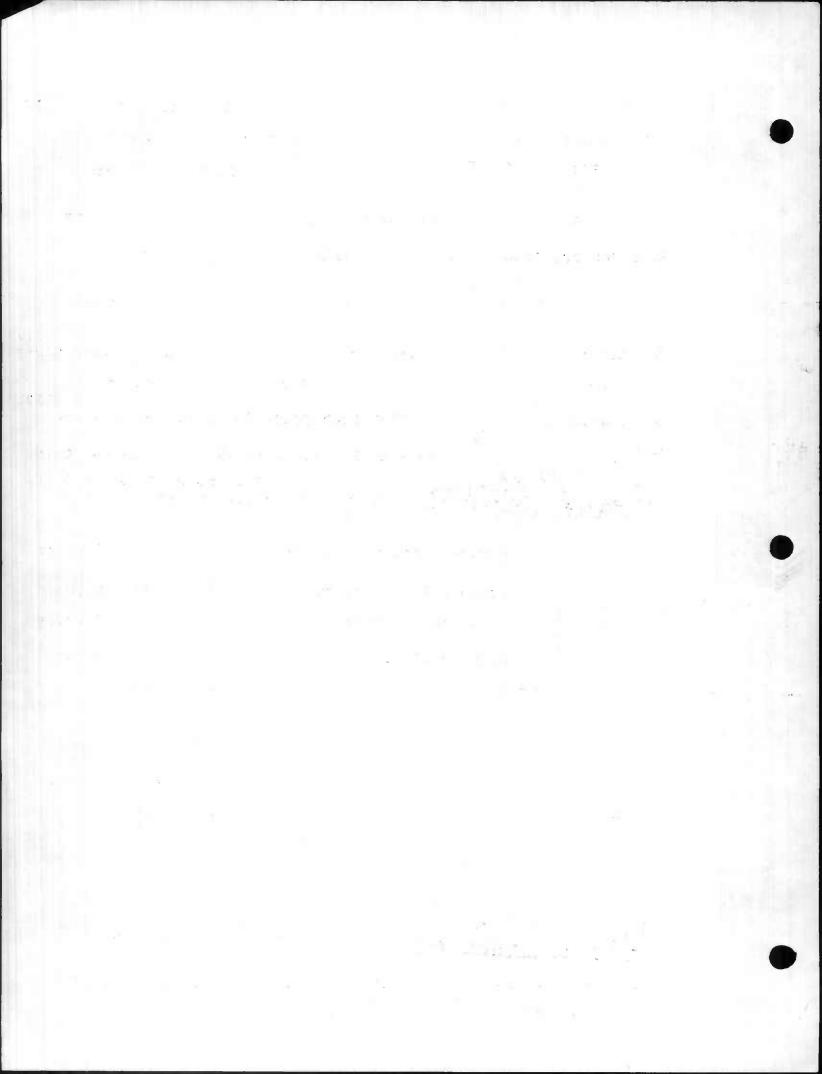
State Registrar 30. Nama and addrass of person who completed ceusa of death (Item 23a) (Type, Print)

9 1999

32. Registrar Signature

Harjit Singh,

31. Data filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 15, 1999 Physician 1600 January Betty Stockett Hortopan /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street end number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Dey, Year) Apr. 27, 1931 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F 212-28-9285 67 Yrs. **Director** Annapolis, MD Usual Residence of Decedent with the Meryland 10c. City, Town or Location Annapolis 10b. County Anne Arundel 10d. Inside City Limits 10a. State r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD 1 ☐ Yes 25 No Director 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 USA 119 Janwall Street permit. Peges 1 and 2 should be filed within 72 hours effer death v. Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Mental Inc. Funerai 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Biack, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Benjamin Fleming Stockett Sr. Mary frances Marshall 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 119 Janwall street, Annapolis, MD 21403 19a. Informant'a Name/Relationship (Type, Print) Charles E. Hortopan - Husband Place of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 1/19 Hillcrest Mausoleum Annapolis, MD 4 □ Donation 5 ☑ Other (Specify) Entombment 22. Name end Address of Facility Hardesty Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not entail ahock, or heart failure. List only one cause on each line. 12 Ridgely Ave. Annapolis, MD Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last g physician and as the buriel-tran Due to for as a c P.O. Box 68760. 950 Po 23b. Did tobacco use contributa to the cause of death? signed by the e Pert II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 2 108 2 □ No 3 □ Probably 4 □ Unknown Records, by 24b. Were autopsy findinga available prior to 24a. Wes an autopsy performed? Completed completion of cause of deeth? is certificate has director, page 2 1 Yes 2. NO 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 → No 10 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After or Attending 1 Natural s after de. \*\*i Director: After 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital • Funeral 29a. Certifier 14 certifying Phyaician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and menner as stated. edical To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) To the F within 2 29b. Signature and title of cartifies 29c. License number 29d. Date signed (Month, Day, Year)

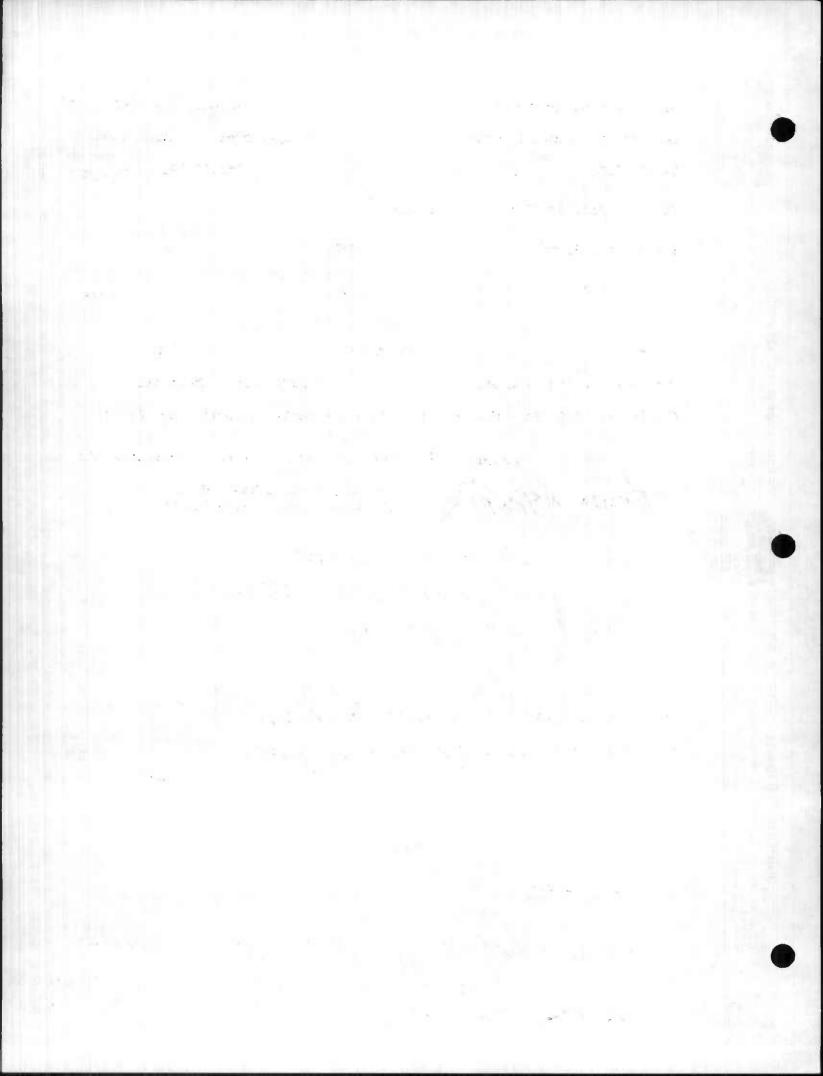
1 23a) (Type, Print)

32 Registrar's Signeture

Registrar

30. Neme and address of person

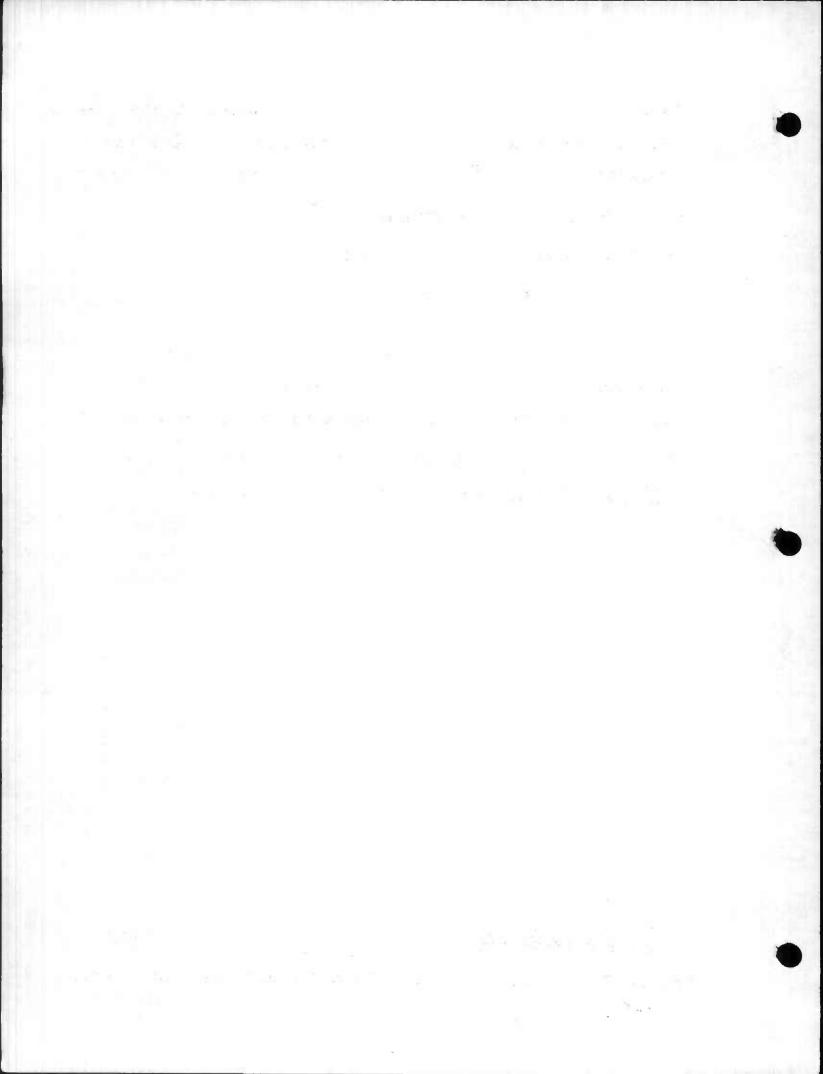
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State of Maryland / Department of Health and Mental Hygiene 9 9 0 7 4 7

					ertificate	e of	Death	F	eg. No.			
Physi	cian	1. Decedant's Nama (First, Middla, Last,						2. Data of Dea Month	th Day	Year	3. Time of Death	
/Med		Joshua Heism						January	12, 19		5:40pm	
Exam	iner	4a. Facility Nama (If not institution, giva						Location of Death	4c. County			
		1904 Sleepy Hollo 5. Social Sacurity Number 8. Sa:		In yrs. last birthd	(av) If Undar		Annapoli  If Under 24 Hrs		Anne	Arun		
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Man Man		10a. Stata 10b. County	1	Oc. City, Town o	r Location					10	Od. Insida City Limits	
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ith with the Marylas 23e or 25e-f show ust be notified at	al Director	10e. Street and Number 73-42 255th Stree		10f. Zip Coda 11001			1	0g. Citizen of V USA	What Coun	try?		
hama herm	by Funeral	11. Marital Status  1 Navar Married 2 Married  3 Widowed 4 Divorced	1√2 Yas 2 No 1 Q50_51		I3. Was Decede If Yas, speci 1 ☐ Yas 2		llspanic Origin? (\$ an, Maxican, Puar Specify:	Specify Yas or No- to Rican, atc.)	o- 14. Race - Amarican Indian, Black, White, atc. Specify: White		atc.	
Mice y lease A. L. L. C. C. C. C. C. C. C. C. C. C. C. C. C.	Completed	15. Decedant's Edu (Specify only highast gradi Eiamentary/Secondary (0-12)			Decedant's Usual Occupation (Giva kind of work dona during most of working ifa. DO NOT usa retired)		orking	16b. Kind of Businass/Industry		tustry		
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2 should and Men is marks aumetic	5	19a. Informant'a Name/Raiatlonship (Ty	ne Print)	19h M	alling Addrass	(Street						
and 2 a saith ar n 27 is er trau		Ross Ian Heisman					and Number or Rural Routa Number, City or Town, Stata, Zip Code) D110W Lane, Annapolis, MD 21401					
5 - 1 9		20a. Mathod of Disposition  1 ☐ Burial 2 ☐ Cramation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	amoval from Stata	20b. Placa of Dicematary, Mt. Ara	cramatory or ot	har plac			20c. Location -			
Deficient Page Department of Important If any Injury or		21. Signature of Funarai Sarvice License		III.	22. Nama and			1/13	diming	dale	142	
i della		1	Hardesty Funeral Home, P.A.  12 Ridgely Ave. Annapolis, MD 21401  Approximate caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and cause on each line.  Approximately a cause of the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and cause on each line.									
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aw requi	Completed							24a. Was e perfor	24a. Was en autopsy performed?  24b. Wara autopsy findir available prior to completion of cause of death?			
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Physician: The I this certificate hard director, page	8	25. Was casa rafarrad to medical axaminar?	28. Piaca of Death (Check only ona)							žwaz.		
Physic this c	10	TLI TAS ESTINO	1   Inpatiant 2   ER/Outpatient 3   DOA   Value 4   Nursing Homa 5   Rasidance 8   Other (Specify)   VESILLEN							n residence		
B en o	cation	27. Manner of Death  1 Natural 5 Panding 2 Accidant invastigation	28a. Data of Injury (Month, Day Year) 28b. Tima of Injury M 28c. Injury at Work? 1 ☐ Yas 2 ☐ No					28d. Dascribe h	28d. Dascribe how injury occurred			
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicida datarmined	28a. Place of Injury building, etc. (	28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)					
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To the To the	Me	296. Signature and life of certifier	Licans	a number	29d. Data signed (Month, Day, Year)			Day, Year)				
2		30. Name end eddress of person who completed causa of daath (Itam 23a) (Type, Prigit) Stravt E. Sclonich, M. 0 900 Batgate Annap										
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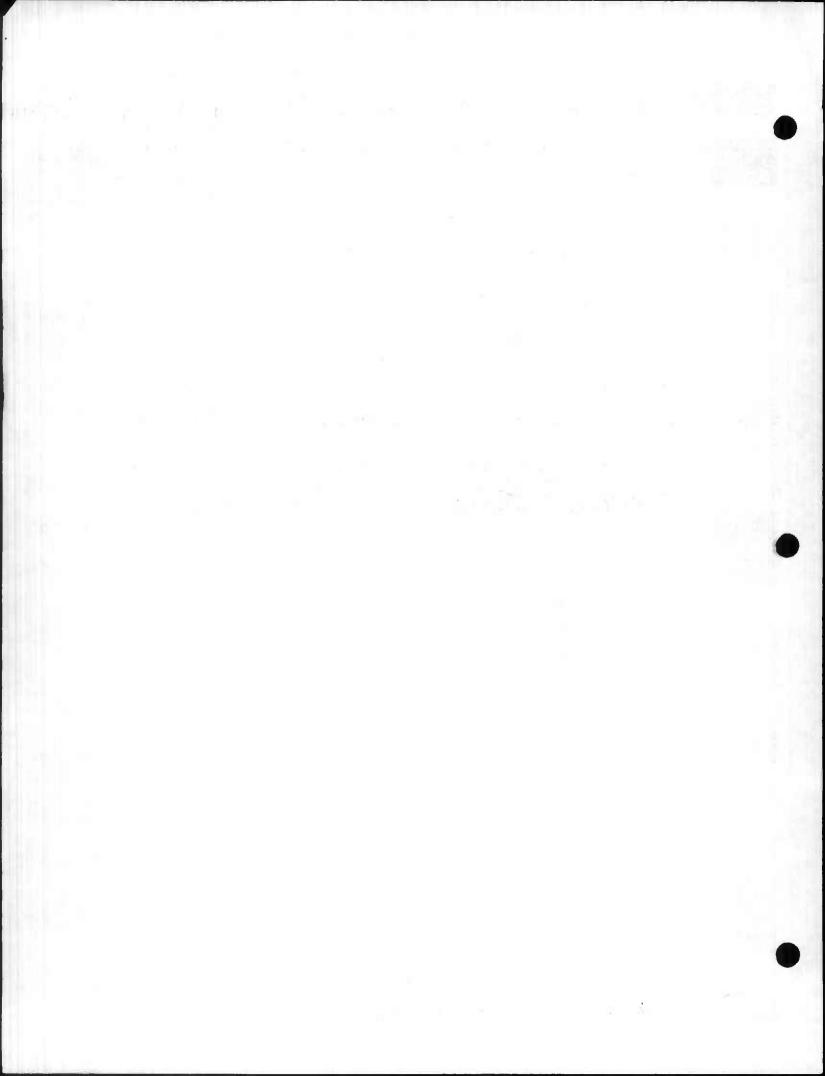


#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month HASER" KATHERINE 101 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Deat Examiner Larkin Chase Nursing & Restorative Center Bowie
If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Prince Georges 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1□M 2√2F 90 Yrs. Director 565-12-2443 Mar.5,1908 Scotland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Depertment of Health and Mentel Hygiene. Important: If term 27 is mented other than "netural; or flame 23a or 28a-f show any injury or other traumatic event, its Moucal Examinet manton notified as New Kensington 1 ☐ Yes 2 XNo Director West Moreland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1014 Kenneth Avenue 15068 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specify: þ Specify: White 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Telephone Operator Telephone 10 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be Andrew Beveridge Catherine Penman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Burlbaugh - Daughter 3002 Twisting Lane, Bowie, MD 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ♥ Othar (Specify)entombment Greenwood Mausoleum 1/20 Lower Burrell, PA 21. Signature of Funeral Servica Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the *mode* of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Examiner iclan end buriaf-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Dug to (or as a consequenca of) Records, P.O. Box 68760. attending physiclan for use es the buna Physician/Medical Due to (or as a consequence of): ed by the a Part II. Other eignificant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? signed by t d be detach 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peed hes certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

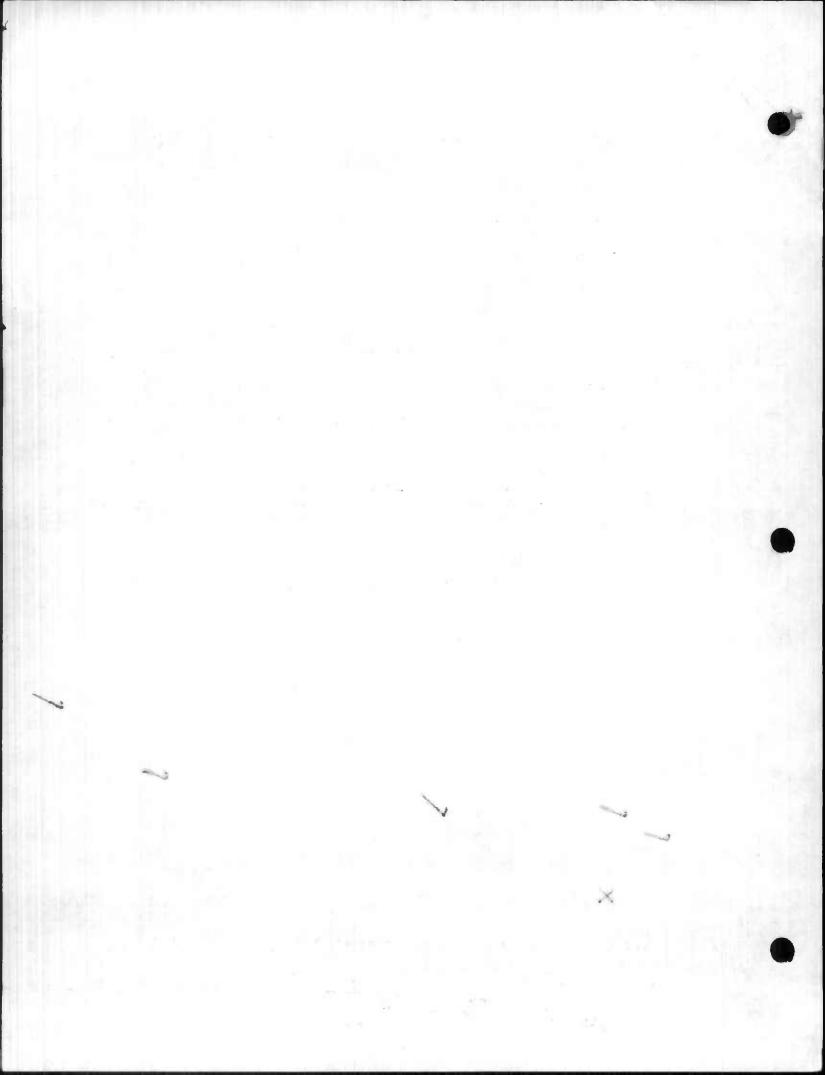
To the Funeral Director: After this certifica 25. Was case referred to medical examinar? Be 26. Placa of Death (Check only one) Hospital: Othar: \* Nursing Homa 5 Rasidenca 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mannar of Death 28a. Date of Injury (Month, Day Year) Certification: 28h Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be datamined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 157 Cartifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifian (Check only one) 29b. Signature and title of certifier ne and address of person who completed cause of death (Item 23a) (Type, Print) 3231 32. Registrar's Signature State Registrar

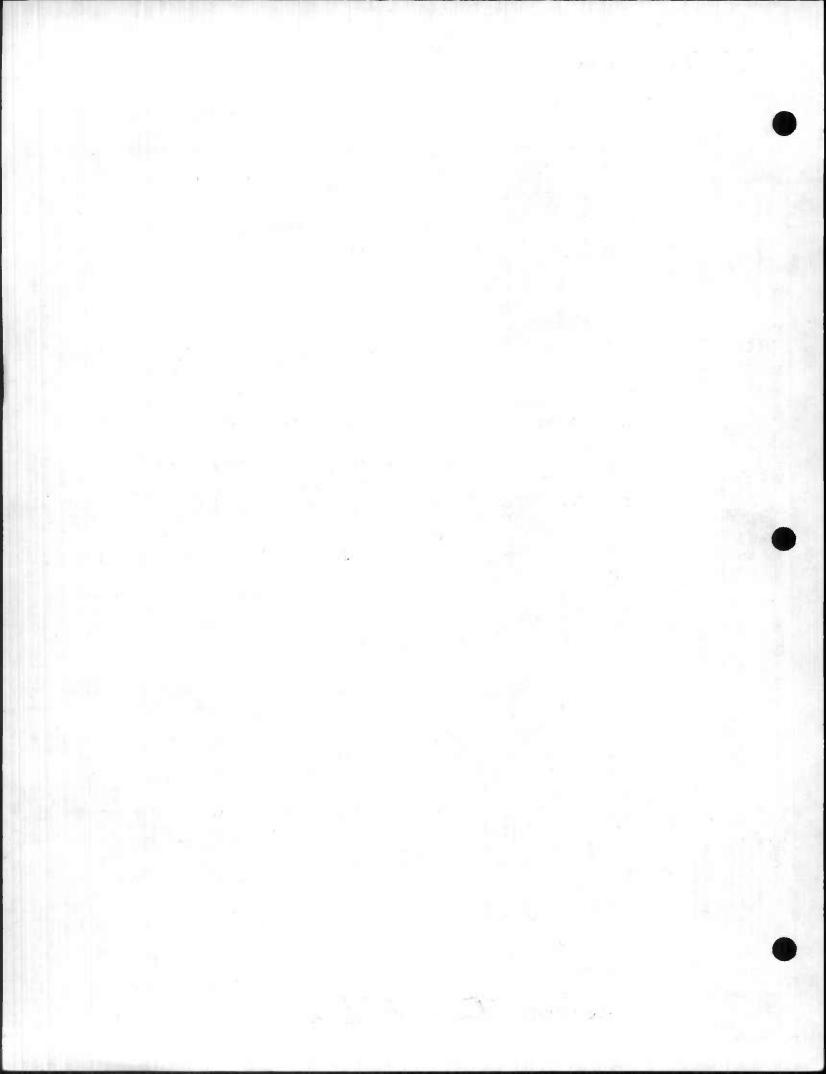


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	Certificate of Death						Reg. No.  2. Date of Death  3. Time of Death				
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kaminer	4a Facility Nama (If not institution, giv				4b. City, Town, or L		4c. County	of Death			
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Funeral Director	11. Marital Stetus 1 Never Merried 2 Married	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		13. Wes Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto F			14. Rac Bled	e - America ck, White, e	otc.		
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buce	21. Signeture of Funeral Service Idear	1//	Cr	Name and Addre	n Societ	y of M	D, Inc	2.			
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State	31. Date filed (Month, Dey, Year)	32. Registra S Sign	neture	1		7 111	0	,	1 110		

State Registrar

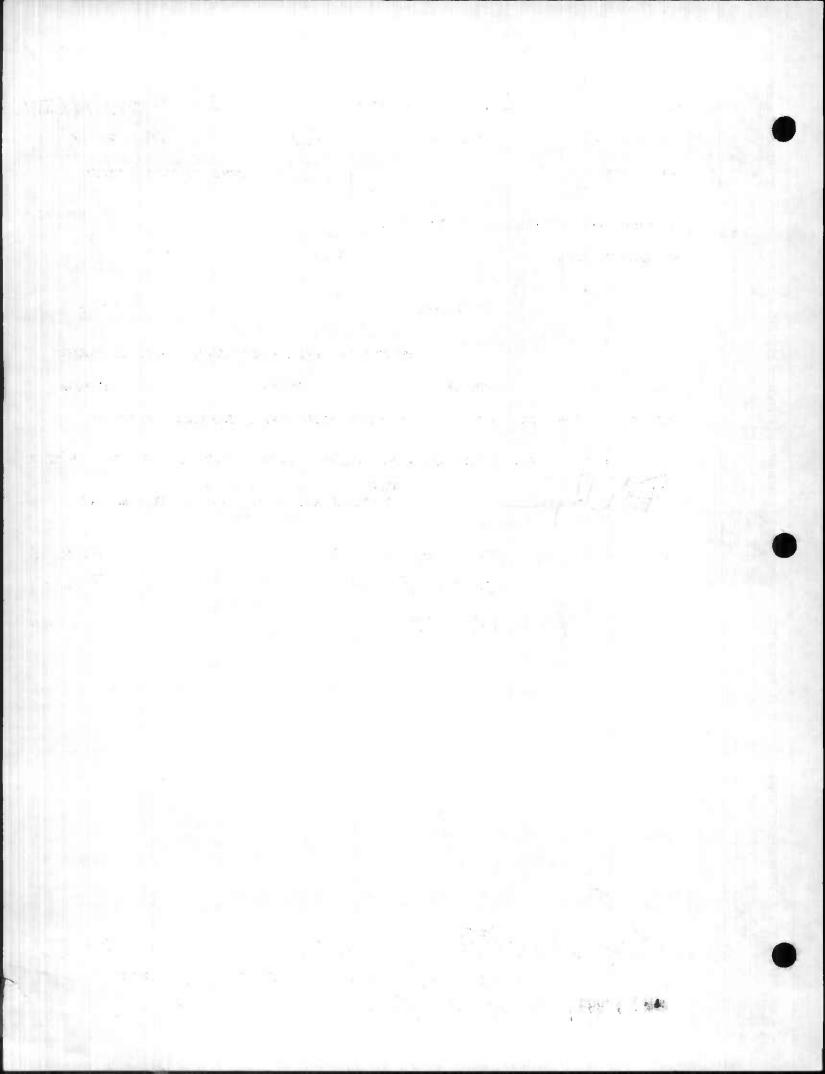




## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1)

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al or	457-09-3079 1X M 2 F 78 Yrs. Month	or 1 Year If Under 24 Hrs. Deys Hours Min.	8. Dete of Birth (Month, Day, Y SEPT . 15	(ear) ,1920	9. Birthplace (State or Foreign Country) TEXAS				
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Director	MARYLAND   ANNE ARUNDEL   PASADENA   106. Street and Number   10f. 2	p Code	100	g. Citizen of Wh	net Country?				
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	29e. Certifier 12 Certifying Physician: To the best of my knowledge, death occurre	at the time date and niece	and due to the cau	ise(s) and man	ner es stated				
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	30. Name end eddress of person who hompleted cause of deeth (Item 23e) (Type, Print)	12 1001		1 101	2/1/1/				
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		had.	-1 47	. /					

Registrar



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Day 12 Month 10:50 A, m **Physician** January 1999 George T. Holliday /Medical 4b. City, Town, or Location of Deeth 4c. County of Deat 4a Feclity Name (If not institution, give street end number) Examiner GLEN BURNIE NORTH ARUNDEL HOSPITAL 7. Age (In yrs. last birthdey) 69 Yrs. If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 220-20-9964 Sept. 14, 1929 **Director** Maryland Usual Residence of Decedent with the Maryland 10e. State 10b. Count 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Baltimore Director MD Severn Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 United States 8125 Silo Court Funerai 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced HOLLIDAY, GEORGE 1 Yes 2 No If Yes, Give X Yeer or Detes: 1 Yes 2 No Specify: Specify: white py Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) Cotlege (1-4or 5+) Retail - Card Store Retail - Self-Employed 18. Mother's Nama (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental George T. Holliday Gussie Roberts 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Pa. informant's Name/Relationship (Typa, Print) 527 Jeffrey Rd., Millersville, MD 21108 Item 27 I Denise Michelle Greeley/Daughter 20b. Placa of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition Department of Himportant: If its any injury or or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Fun. Crem. 1/14/98 Alexandria, VA Other (Specify) 4 Donation 22. Name end Address of Facility Loudon Park Funeral Home. Baltimore, Maryland 21229 3620 Wilkens Avenue Baltimore, Maryland 21229

Intl. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errast, hock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) NO DIVES WEEKS Examiner Physician/Medical Examiner and I-transit certificata be executed Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury physician an s the burial-tr Division of Vital Records, P.O. Box 68760, that Initiated events resulting in death) Last 80 189 0 23b. Did tobacco use contribute to the cause of death? signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilebte prior to completion of cause of death? 24a. Was an autopsy Completed iractor, page 2 s 1 Yes 2 No 2 No 1 Yes Physician: 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Rasidanca 8 Other (Specify) 1 Yes 2 No 10 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28h Time of 28c. Injury at Work? Certification: Aftar 1 Naturat or Attending 5 Panding 1 Yes 2 No n 24 hours efter deeth.

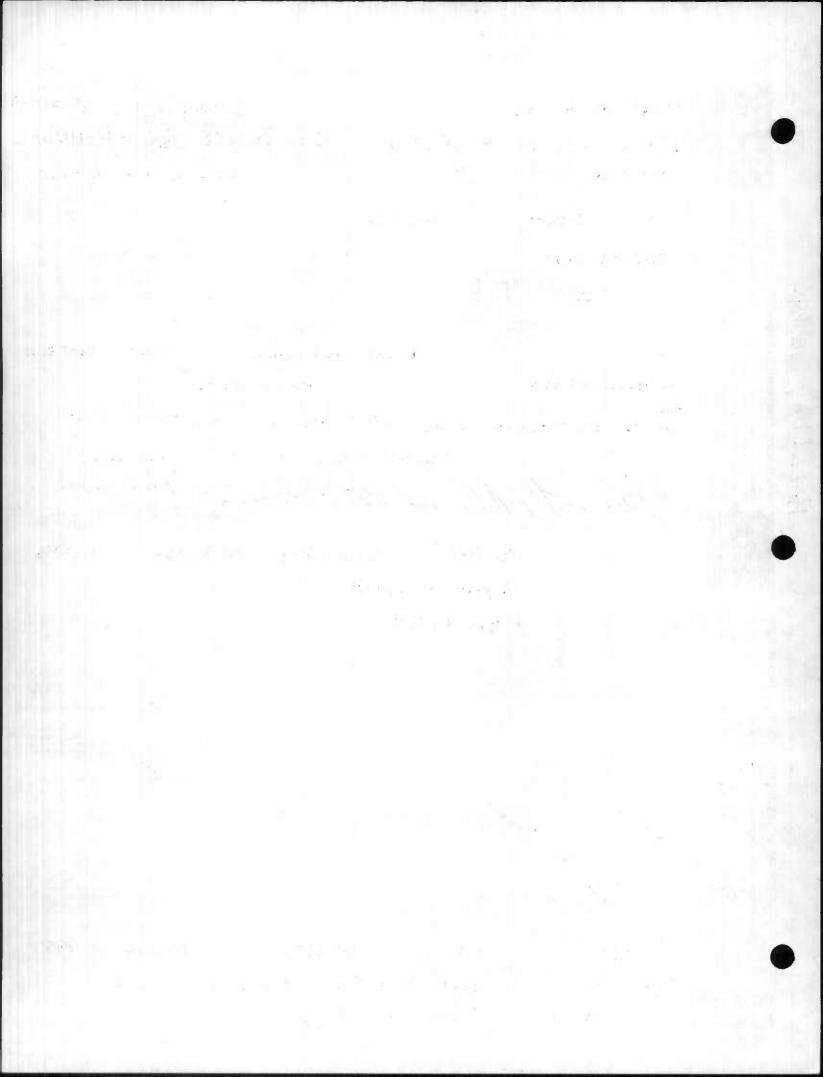
Ne Funeral Director: Al deeth. investigation 2 Accident 28f. Location (Streat and Number or Rurel Route Number, City or Town, State) 6 Could not be 3 ☐ Sulcide 28e. Ptace of tnjury - At home, farm, street, factory, offica building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledga, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29a. Cartifiar To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of cartifier 29c. License number ms 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) Orkfung , 301 Am tal DRIVE, Citen Gusnie mo. 31. Date filed (Month, Dey, Year) State

DHMH 16 Rev 6/95

Registrar

JAN 191999



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 15, 1999 4c. County of Death 11:00 AN January 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) Baltimore AGNES HEALTHCARE If Under 1 Year | if Under 24 Hrs. Birthplace (Stata or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1 M 2 F Days Hours Min Yrs. MAR. 22,1927 MARYLAND 215-22-8881 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 1 □ Yas 2 □ No **MARYLAND** N/A BALTIMORE 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 1111 E. PRESTON STREET 21202 U.S.A. 12. Was Dacedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-it Yas, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Marriad 2 Married 1 Yes 2 No Specify: AFRO-AMERICAN 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) FILE CLERK BANK 9TH 17. Father'a Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumame) **GEORGE** ANDERSON ROWENA THOMPSON 19a. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAWN SMITH DAUGHTER BALTO, MD. 4004 W. RODGERS AVE. 21215 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LOUDON PARK CEMETERY JAN. 21, 1999 BALTO, MD. 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death non-small cell lung cancer Immediata Cause (Final disease or condition rasulting in death) Due to (or as a consequence ot): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaase or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Dua to (or as a consequenca ot): 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 2N No 25. Was cese raferred to medicel examinar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of injury (Month, Day Year) 5 Pending 1 Natural 1 Yes 2 No investigation 2 Accident 28t. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 3 ☐ Suicide

NAME HENSON, MAMTE E EDIVISION of Vital Records, P.O. Box 68760,

use es the burial-transit signed by t page 2 certificate funeral

**Physician** 

/Medical

Examiner

**Director** 

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Directo

Funeral

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Completed

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and Mental Hygiene.

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29a. Certifian

Baltimore, Maryland 21215-0020

Attending Physician: s after death. filled in by 24 hours within 2. 9

Registrar

29b. Signature and title

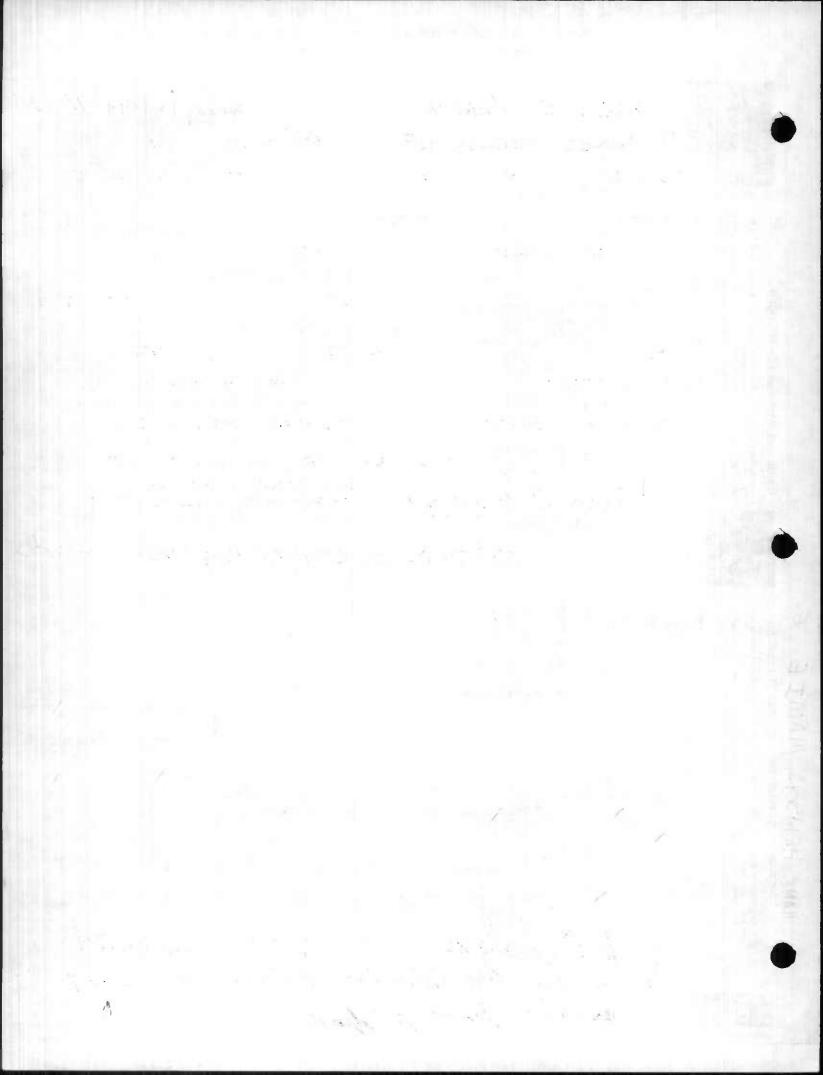
1 Cartifying Physician: To the bast of my knowladge, death occurred at the time, date and place, and dua to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who complated cause of death (Item/23a)/(Type, Print)

aton 31. Data tiled (Month, Day, Year)

BoHIMOVE MD



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		State of M	Maryland / [	Department of Certificate of		d Mental Hy	giene Reg. No. 9	00754
Physician /Medical	Decedent's Name (First, Middle, George	ce Edmund l	Haas			2. Date of De Month Jan.		aar 20:30
Examiner	4a Facility Name (If not institution, g				4b. City, Town, Westmi	or Location of Deat .nster	h 4c. County of	
Funeral Director	212-20-6007	. Sex 1 M 2 F 7. /	Age (In yrs. lest bir 72	thday) If Under 1 Yea Months Days		lin. (Month, De	th Year) 9 29, 1926 1	Birthplaca (State or Foreign Country) Mary Land
Maryland f show led.at	Usuaf Residence of Decedent  10a. Stafe  10b. County  Md. Carr	ell	10c. City, Town	n or Location Impstead				10d. Inside City Limits 1 ☐ Yes 2 No
h with the Ma the or 28er's at be notified		Hill Dri	re	10f. Zip Code 2107	4		10g. Citizen of Who	
5-0020 72 hours after death or studies, or itsens 23 disel. Examiner, must sted by Funeral	3 ☐ Widowed 4 ☐ Divorced	12. Wes Deceder Armed Force: 1 1 Yes 2 I If Yes, Give Yeer or Detes	S? No WW TT	13. Wes Decedent of If Yes, specify Cu		(Specify Yes or No Jerto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
Maryland 21215-0020 02 should be filed within 72 hours at the and Merial hygiere. The merised other than "natural", or traumstic event, the Madical Exam To Be Completed by 8	15. Decedent's (Specify only highest s Elementary/Secondary (0-12)	rade completed) College (1-4o		Decedent's Usual Occu (Give kind of work don- life. DO NOT use retire celfemploye	d Contra	ctor	16b. Kind of Busin	
yland ould be file Mental Hy Mental Hy wife even To Be	George Ac	bert Haas			Ge	ertrude B.		
CSNL	19a. Informant's Name/Reletionship Dorothy Haas		1	Meiling Address (Street 310 Wolf H		Hampstee	ad, Md. 23	1074
altimore, mil. Papes 1 as partment of Heam portant: if Isam it Injury or other	20a. Method of Disposition  1 Burial 2 Coremetion 3  4 Donation 5 Other (Special Coremetics)		e cemeter	Disposition (Name of y, cremetory or other plane) Crematory		Date 19, 1	20c. Location - Cit	
Balt permit. Depart importa any inj ance.	21. Signature of Funeral Service Lic	limeth			t Funera	l Chapel	Owings M	21117
CB760, CM Control of the control of	Cause (Disease or Injury that initiated events	a. Righ	Due to (or es a c	consequence of):	ebro vaceu	lar acc	ident	23 days
P.O. Box net the deeth cert d by the ettendin leteched for use	Part II. Other significant conditions							bute to the cause of death?
Vital Records, iden: The lew requires the conflicte has been alone rector, page 2 should be defected by	myocandial in	faction				24a. Was perfo	an autopsy omed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital Ricent The Incontillers he Irector, page be Com	25. Was case referred to medical examiner?				26. Place of I	1 □ Death (Check only		1 ☐ Yes 2 No
ang Phys h. After this funeral di	1   Yes 2   A   No  27. Manner of Death 1   Naturat   5   Pending   Investigat 2   Accident   Accid	28a. Dete of tr (Month, E		ime of 28c. tnj	ury at ork? ] Yes 2   No	28d. Describe		
Division within Exportation Attenuable to Attenuable the dealer dealer completely filled in by the Medical Certifical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exp	Physician: To the besiminer: On the basis end menner:	of examination and	, deeth occurred et the the thoral desired to the the three transfer of the three transfer of the three transfer of the three transfer of the	ime, date end pl opinion, death o	ace, and due to the courred at the time,	cause(s) and mann date and place, and	er as stated. If due to the cause(s)
To the Within to	29b. Signature and title of certifier  Lisa Jun  30. Name and address of person who	m completed cause of	D deeth (Item 23a) (		se number  5 2 4 1	9	January	
State Registrar	HOSPital at 200 31. Date filed (Month, PANY) earl	memoria	Avenue trar's Signeture	westmi	nster	MD 2	1157	comy Chemeral

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ORIGINAL

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by Completed Be 2 Certification:

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signed b

Dage 2

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After Attending

To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fun

To the To the To the I

Box 68760

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Records,

Division of Vital

The lew requires that

	disease or condition resulting in death)	a	TE ETHANOL AND COCAINE INTOXICA  Due to (or as a consequence of):	TION
Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to (or as a consequence of):	
Medical	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or as e consequenca of):	
and a		d		
Physic	Part II. Other significant condi	tions contributing to	death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contributa to the cause of death?  1   Yea 2   No 3   Probably   Unknown

24a. Was en autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6XO (ther (Specify) SCENE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? A

28a. Date of Injury (Month, Day Year) Found: 1-11-99 5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide

Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Found: М

1 Yes 2 No

28d. Describe how injury occurred

UNKNOWN

281. Location (Street and Number or Rural Route Number, City or Town, State) # 1 4 \_ Gt\_:IDER\_DRIVE BALTIMORE COUNTY,

29a. Certifier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and little of certified

Dennis

29c. License number O.C.M.E.

29d. Data signed (Month, Dey, Year) JANUARY 12,1999

24b. Were autopsy tindings eveilable prior to

completion of causa of death?

1 XXes 2 □ No

no o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Chute

NO

FOUND IN HOUSE

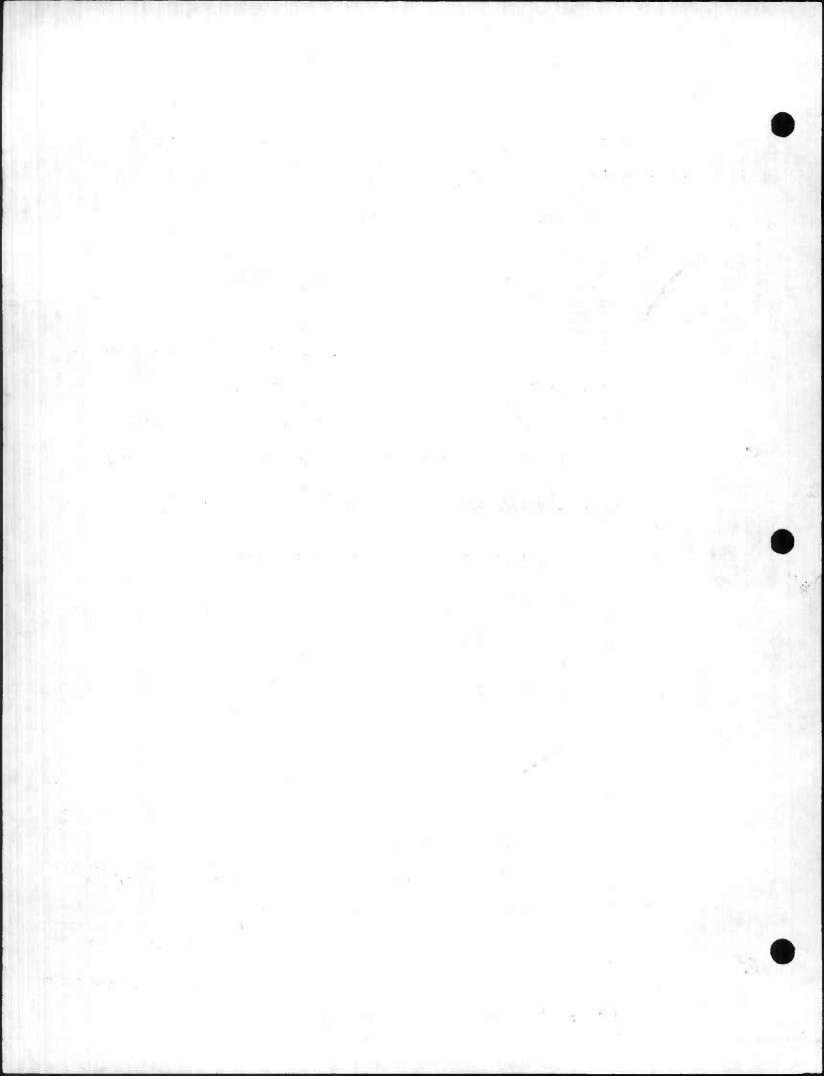
111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medical

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32. Registrer's Signetura



## Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible.

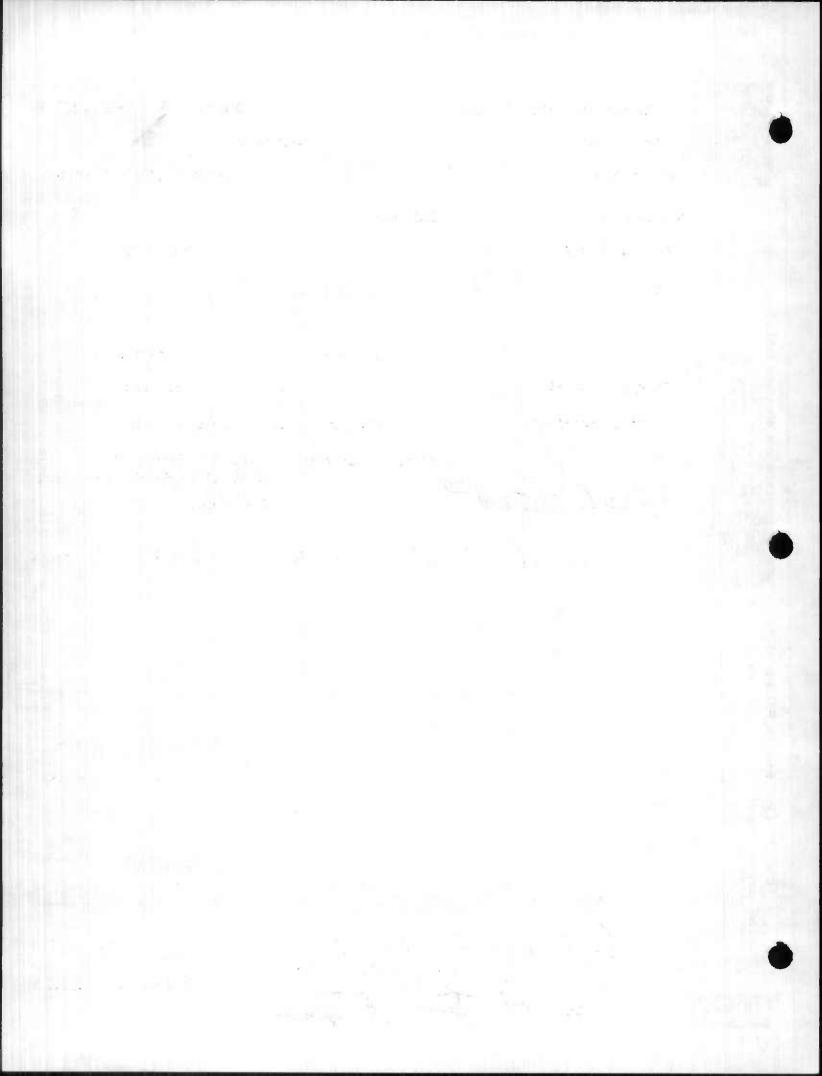
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 8:05 PM January 15 1999 Martha Josephine Hubbard /Medical 4a Facility Name (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick Home Baltimore If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F Yrs. 220-30-2838 83 Maryland **Director** September 6,1915 Usual Residence of Decedent with the Manyland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 □ No Maryland N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be a 700 W. 40th St. 21211 United States Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - American Indian. 11. Marital Status Biack, White, etc. 1 Never Married 2 Married 1 Yas 2 No Specify: white by 3 Widowed 4 Divorced Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) librarian university 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Charles Hubbard Marie (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Carroll Fahey/nephew 350 Homeland Southway Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 N Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/18/99 Druid Ridge Cemetery Pikesville, Maryland 22. Nama and Addrass of Facility Mitchell-Wiedefeld Home, Inc. 21. Signature of Funaral Service Licensee 6500 York Rd. nt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, nock, or heart lailure. List only one cause on each line. 21212 MD Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finat disease or condition resulting in death) RGANIC PEMENTI eaus Examiner Physician/Medical Examiner physician and the burial-transit The law requires that the death cartificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): as l usa for signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yss 2 X No þ 24b. Wera autopsy findings available prior to completion of ceuse of death? been si should l 24a. Was an autopsy Completed cartificata has b 1 Yas 2 No 1 Yes 2 No or Attending Physician: director, 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 28a. Date of injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Aftar 1 Natural 5 Pending 1 Yes 2 No daath. Investigation I Director: A 2 Accident 6 Could not be determined 3 ☐ Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aftar To the Funeral Director complataly filled in b Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) Within 2 To the 29d, Date signed (Month, Dey, Year) 29b. Signature and title of certif 29c. License number

(Item 23a) (Type, Print)

9 1999 N

State Registrar



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	* REGISTRAR CERTIFIC	AIE OF DEATH	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)  MARY MERCITA HERRMA  4. SOCIAL SEQURITY NUMBER  5. SEX  6. AGE (In yrs. Inst birthday)	~	2. DATE OF DEATH DA	7 1999	3. TIME OF DEATH  A M
	220-05-5096 1 M 2 WF 80 YRS. M	ONTHS DAYE HOURS MIN.	7. DATE OF BIFTIN (Morith, Day, Year)	1918 Cour	MD
TOR		BALTIMORE		BALT	IMORE
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, 1	TOWN OR LOCATION			10d. INSIDE CITY LIMITS? 1 YES 2 1 NO
FUNERAL	6401 N. CHARLES ST.	101. ZIP CODE -2/2.	12	10g. CITIZEN OF	WHAT COUNTRY?
BY	11. MARITAL STATUS  1 Mover Married 2 Married  3 Widowed 4 Divorced  12. Was DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPA If yes, specify Cuben, Mexico 1 ☐ YES 2 ☐ NO Specifi	in, Puarto Ricari, atc.)	Bin	CE — American Indian, ck, White, etc.
PLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  5 +  TEACH	k done during most of working retired.)	1000	CHIAL	SCHOOLS
E COMPL	17. FATHER'S NAME (First, Middle, Last) FRANCIS HERRMAN		ME (First, Middle, Malden		ZIEHL
TO B	190. INFORMANT'S NAME (Type/Print) BERNICE FEILINGER 6401	DDRESS (Street and Number or Rural			MD 2/2/2
	20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF			CATION - City or EN AR	
	DAMES TESTED TO A BIN	22. NAME AND ADDRESS OF FA			
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):	OF THE BRE		ratory arrest,	Approximate interval Between Onset and Death  3 YEARS
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):	i			
EDICAL C	PART II. Other significant conditions contributing to death but not resulting in	the underlying cause given in	Part I. 24a. WAS AN PERFOR	RMED?	4b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES		N 🗆		1 TES 2 NO
PHYSICIAN:		OTHER:  Nursing Home 5  Residence	a		
НХ	27. MANNER OF DEATN 28s. DATE OF INJURY 28b. TIME (Month, Day, Year) INJURY	OF 26c. INJURY AT	28d. DESCRIBE NOW I	NJURY OCCURED	
В	1 Natural 5 Pending 2 Accident Investigation 3 Sulcide 2 2 Se. PLACE OF INJURY — At home, term, str	M 1 TYES 2 NO	261. LOCATION (Street		if Route Number,
TED	4 Nomicide determined building, atc. (Specify)		City or Town, State)		
COMPLET	29a. CERTIFIER (Check only one)  2 MEDICAL EXAMINER: On the basis of examination and/or investigation,				e(s) and manner as stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NU	MBER	29d. DATE SIGN	ED (Month, Day, Year)
TO B	30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF BEATN (ITEM 27) (Type, F	DO 13	13	11/1	/ 77
,-		5 OSLER T	KINE B	ALTO	MD 21204
	31. DATE FILED (Month, Day, Year)  PRIN 1 0 1000	la di			

And the second second second 

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death Month Ruth 4:58 AM Н. Hardesty 16, 1999 January 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rosedale ranklin Square Hospital Center Baltimore 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) ear If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthpiaca (State or Foreign Hours 10 M 21 F Months Days 235-20-1422 76 Yrs. Feb 6, 1922 W. Virginia Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 ☒ No MD Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2901 B Dunran Rd 21222 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, Whita, atc. 1 Never Married 2 Married 1 Yes 21 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Byron C. Hinkston Georgia Molisee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Bowman /daughter 38 Admiral Blvd. Baltimore, MD 21222 20a. Method of Disposition 20b. Placa of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date Jan 19 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Damon Cemetery 1999 Newburg, W. Virginia 21. Signature of Funeral Sarvice Licenses 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 23a. Part1. Enter the disear or complications that caused the death. shock, or heart failure list only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between Onset and Death Immediata Causa (Final · ARTERIAL and VENOUS THROM bosis 4 days disease or condition resulting in death) Due to (or as a consequence of) ThrombocytopENIa Heparin INDUCED Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Gastrointestinal Bleed 1 ☐ Yea 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to Chronic Distructive Pulmonary Pisease completion of cause of death? 2000 1 ☐ Yes 2 ☐ No 25. Was casa raferred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Matural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

Examine ician and buriel-transit physician s the buriel Box 68760. that the death certificate be P.O. Records. Division of Vital this Certification: Attending death. 5

Physician/Medical Completed by Be

**Physician** 

/Medical

**Examiner** 

Director

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**Funeral** 

Director

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2 should be fi and Mental H is marked off

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

tardesty,

24 hours after death • Funeral Director: A sietely filled in by the

within 24 hor To the Fune completely fi

**DHMH 16 Ray 6/95** 

State Registrar

29a. Certifier

(Check only one)

29b. Signature and time of certifier

Dr. Dawn Warner 31. Data filed (Month, Day, Year) JAN 16 1999

32. Registrar's Signatura

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

Square Dr. Battimore, Maryland 21237 9000 FRANKlin

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

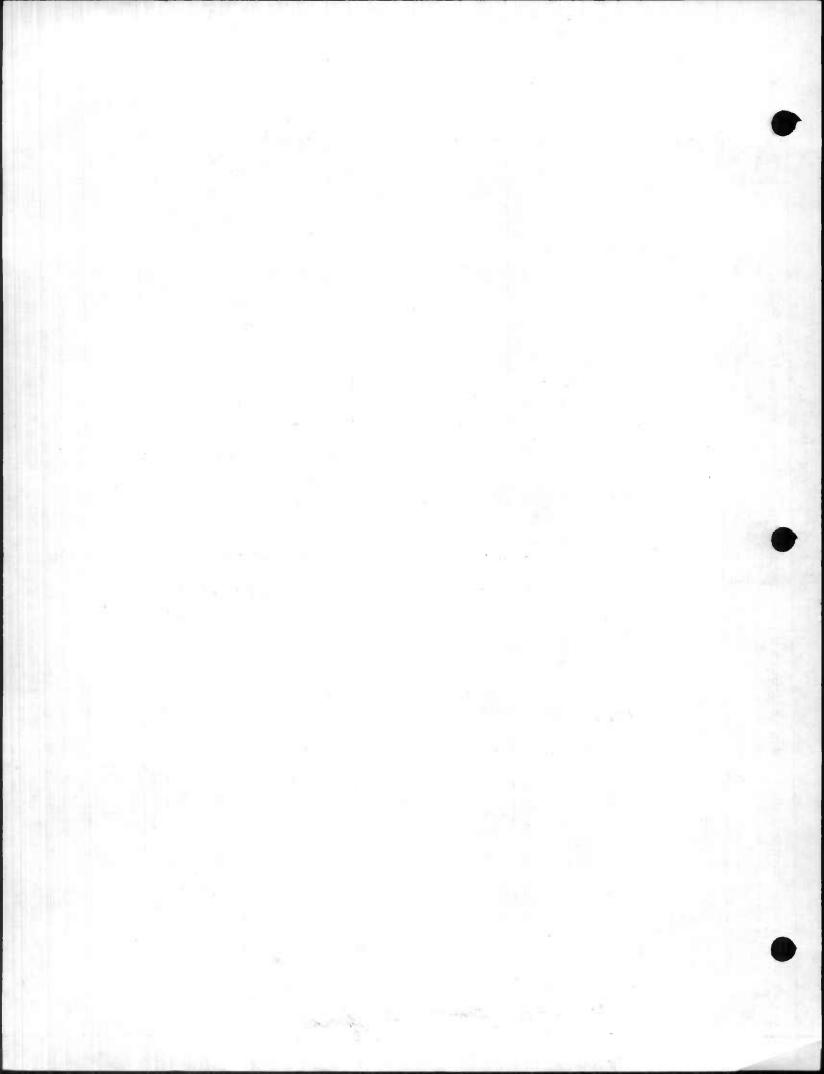
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RD 187252

29d. Data signed (Month, Day, Year)

**ORIGINAL** 



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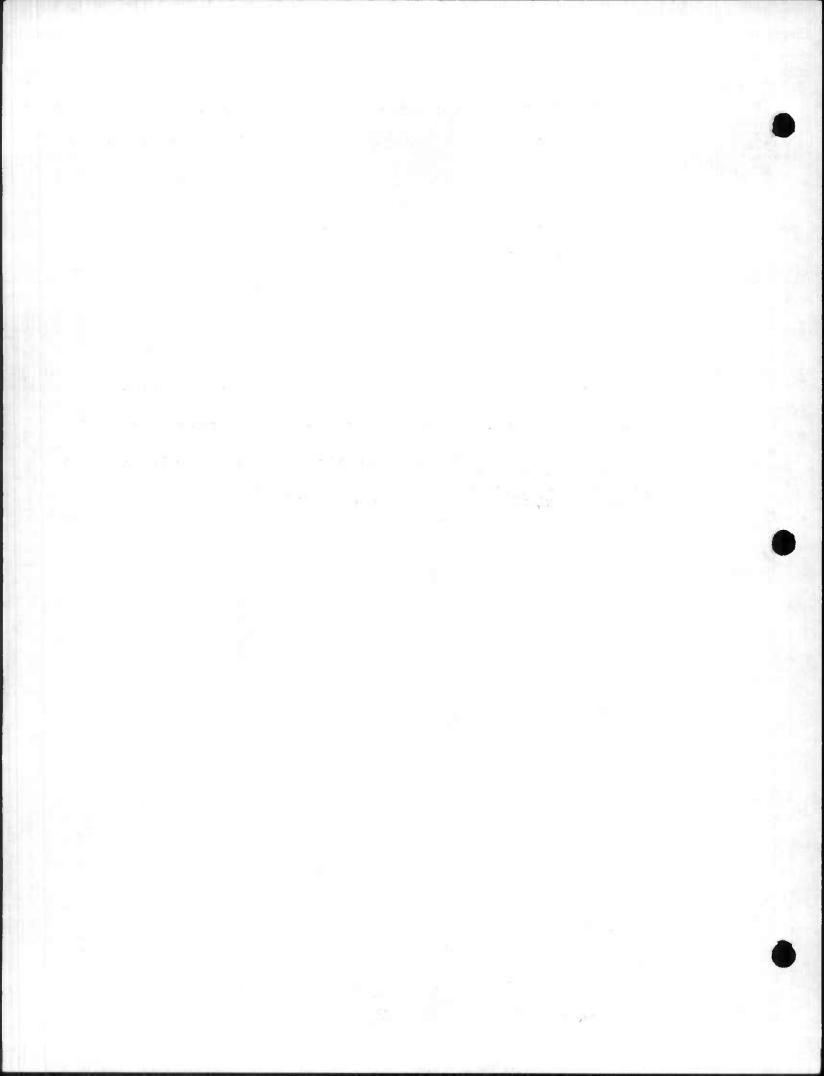
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death **Physician** Month Yeer JAN 15 1999 WIILIAM ALFRED JONES SR /Medical unkrown 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner SJNAI HOSPITAL CENTER BALTIMORE CITY If Under 1 Year 5. Social Security Number If Undar 24 Hrs 8. Data of Birth (Month, Dey, 7. Age (In yrs. lest birthday) Birthplace (Stete or Foraign Country) **Funeral** 17€M 2□ F Days Yrs Director 56 229-58-5218 AUG 4 1942 VIRGINIA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at XX Yes 2 No Director **MAFYLAND** N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Items 23a 4027 W. COLDSPRING LANE 21215 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. should be filed within 72 hours after und Mental Hygiene. marked other than "natural", or Iter 1 ☐ Yas 2 X No If Yas, Give Yaar or Dates: 1 Never Marriad 2 Married 21215-0020 1 ☐ Yes 2XXVo Specify: BLACK by 3 Widowed 4 Divorced Completed traumatic avant, the Medical 15. Dacedant's Education (Spacify only highest greda completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN SMITH BAKING COMPANY 12th grade Baltimore, Maryland 17. Father's Name (First, Middle, Lest) 18. Mothar's Name (First, Middle, Meiden Surnama) Be th end Mental It Pages 1 and 2 should be JAMES EDVARD JONES CEDDRA JONES 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Numbar or Rural Route Number, City or Town, Steta, Zip Code) permit. Pages 1 and 2 is Department of Health er Important: If itam 27 is any Injury or other trau once. Christine Jones/Wife 4027 W. Coldspring Lane, Baltimore Maryland 21215 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 1-22-99 BALTIMORE, MARYLAND 21. Signature Funeral Şervice License 22. Name and Address of Facilit WIILIAM C BROWN COMMUNITY FUNERAL HOME PA ara 1206 W. NORTH AVENUE Part1. Enter the diseese, or complications that causad the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata interval Between Onset and Death **Physician** MULTIPLE /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Examiner physician and the buriel-transit be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other aignificant conditions contributing to death but not resulting in the underlying causa givan in Part i. P.O. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Records, 24b. Wara autopsy findings available prior to completion of cause of death? been si 24a. Was an autopsy performed? Completed page 2 1 Yes 2 No certificate Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Diractor: After this certifica Be 25. Was casa rafarrad to medical axaminar? 26. Pieca of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Hospital: 10 1 ☐ Yes 2 1 100 1 Impatient 2 ER/Outpetient 3 DOA 28a. Deta of Injury (Month, Dey Year) Certification: 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No Investigation 2 Accident ractor: 6 Could not be detarmined 3 Sulcida 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 T Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the ceuse(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 To the I 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addrass of person who complated causa of death (Itam 23e) (Type, Print) R. KRISHNAN, MD NIEVTAN ST # 305 BALTIMORE 21201 821 31. Date filed (Month, Dey, Year) State JAN 1 9 1999 Registrar

DHMH 16 Ray 6/95

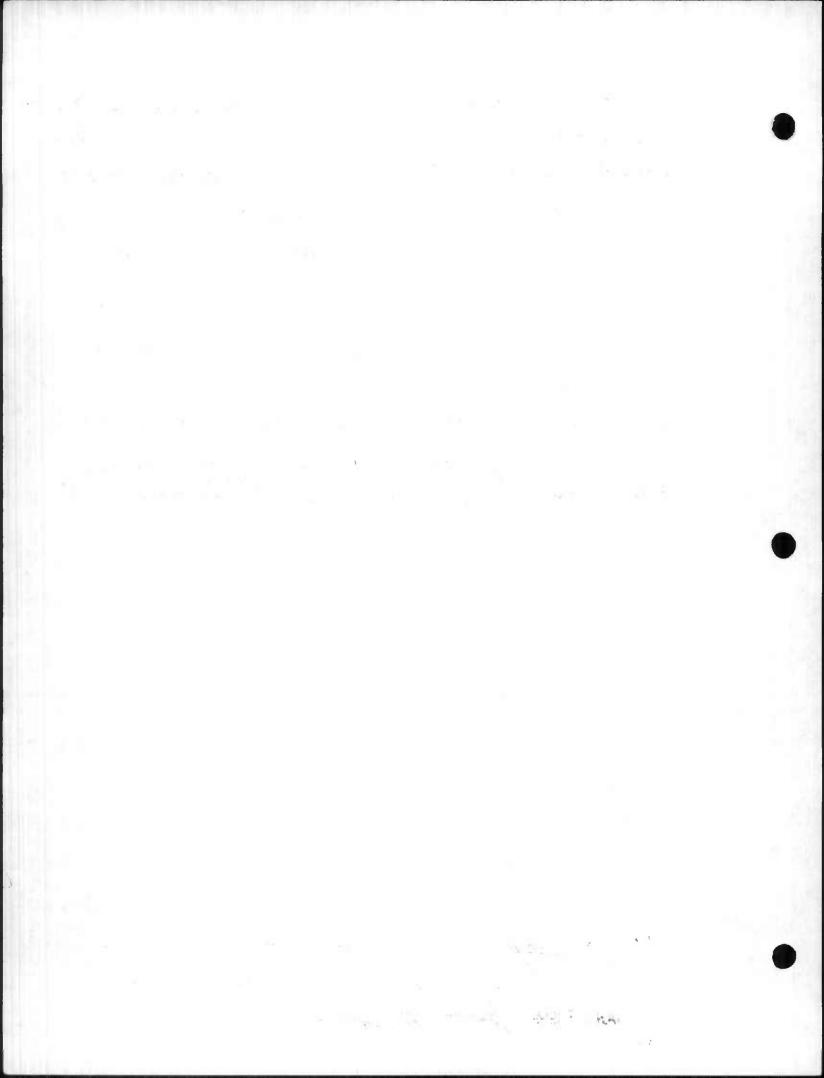
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 0 7 6 0

			State of Maryland /	Certificate of			g. No.	
	Physic /Medi		1. Decedent'e Name (First, Middle, Last)  Madelene Agatha John	nston		2. Date of Death Month JAN 15	Dey	3. Time of Death Year 10:32 AM
	Examir		4e. Facility Name (If not institution, give street and number)		4b. City, Town, or L		4c. County of	
			61 Franklin Street		Annap			Arunde1
L	Funeral Director		5. Social Security Number  6. Sex 1 M 2 M 2 M 9 0  Usual Residence of Decedent	Yrs. If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, OCT 11,	Year) 1908	9. Birthplace (State or Foreign Country) Missouri
	inyland show		10a. State 10b. County 10c. City, Tow	n or Location				10d. Inside City Limits
	he Me	Director	MD Anne Arundel		polis			1 No 2 No
	ter death with the Marylan items 23a or 28a-f ahow inst must be notified at	al Dir	10e. Street end Number 61 Franklin Street	10f. Zlp Code	1401	10	g. Citizen of W	15. 100.
020	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ahow ha Madical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Merried 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Wes Decedent Ever In U,S. Armed Forces?  1 □ Yee 2 ☑ No If Yes, Give Year or Dates:	13. Wes Decedent of H If Yes, specify Cube		ecify Yes or No- Rican, etc.)	14. Race	- American Indian, , White, etc.
Maryland 21215-0020	d within 72 hours affiliene.", or r than "natural", or the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Uaual Occup (Give kind of work done life. DO NOT use retired	etion during most of work d)	ing 1	6b. Kind of Bus	
d 2	77 70 10		17. Father's Name (First, Middle, Last)	Homemaker	18 Mother's Nam	e (First, Middle, M		Home
ylan	0 0 0	To Be	Roy B. Thomas			cence E		
Mar	2 sh and in me			. Malling Address (Street				
	Te al		John T. Johnston/Son 16  20a. Method of Disposition 20b. Place o	520 Riggs f Disposition (Name of ry, crematory or other plea	Place N			C 20009 City or Town, Stete
nor	ages ont of t: If it y or o		I Dunar 2 Dicientation 3 Dicentover from State			200		
Baltimore,	permit. Pages in Department of Firmportant: If its any injury or of once.		21. Signeture of Purerel Service Licenses	Crematory 22. Name and Addre	ss of Fecility			
30)	Per ing per per per per per per per per per per		Edward A. Gregorchik	299 Fred	n Societ erick Ro	y of Mi	D, Inc	e, MD 21228
	Physician		23a. Pert1. Enter the disease, or completions that caused the death. Do ahock, or heert tailure. List only the cause on each line.	not enter the mode of dylr	ng, such es cardiac	or respiratory arre	st,	Approximete Interval Between Onset and Death
	/Medicai Examiner		Immediate Cause (Finel disease or condition resulting in death)  a.   MUTIPHS  Due to (or es a	= m/B	Lomi	9		5 mo
	D is	iner	TU BIZNEUZ	consequence or):				6 uss
, 0,	ificate ba arecuted g physician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  Due to (or as e.g., procedure)	consequence ot):				
x 68760,	E 0 6	-	resulting in deeth) Last	consequence of):	-			
Box	that the death cert ed by the attendin detached for use	Physician/N	d					
o.	the de	iysic	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause giv	en in Part I.			tribute to the cause of death?
О.		by Ph				1 Ye	8 2□ No	3 Probably 4 Unknown
Vital Records,	been s should	Completed				24a. Was an perform	eutopsy ed?	24b. Were autopsy findings available prior to completion of cause of death?
E E	The ate h	Con				1 ☐ Yes	2 No	1 Yes 2 No
Zi Zi	Physician: this certific ral director,	Be	25. Was case reterred to medical examiner?	Oth	00	h (Check only one		
of	5 5 5	tion: To	27. Menner of Death 28a. Date of Injury 28b.	Time of 28c. Injury	4 Inursing Ho	me 5 Resider 28d. Describe hov		
Division	To the Hospital or Attending Phywithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral	Certification:	3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)			28f. Location (Stre City or Town,		r or Rural Route Number,
	Hospita 24 hours Funeral tely fille	edical C	29a. Certifier (Check only Medical Examiner: On the basis of examination an	o, death occurred at the tin d/or investigation, in my o	ne, date and placa, plnion, deeth occur	and due to the cau	use(s) and man	ner as stated. nd due to the cause(s)
	othe ithin 2 mple	Med	one) and manner stayed.  29b. Signature and title by dentitier	/ 29c. Licens	e number	29	d. Date signed	(Month, Day, Year)
	F 3 F 8		1 July 1 Mann.	1 D	68118		1/15	199
	10		30. Name and address of person who completed cause of death (Item 23a) Stanley Watkins, MD 900 Best		Annana	da MD	21/.01	
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registra & Styneture	7 6	Annapo	IS, MD	714UI	

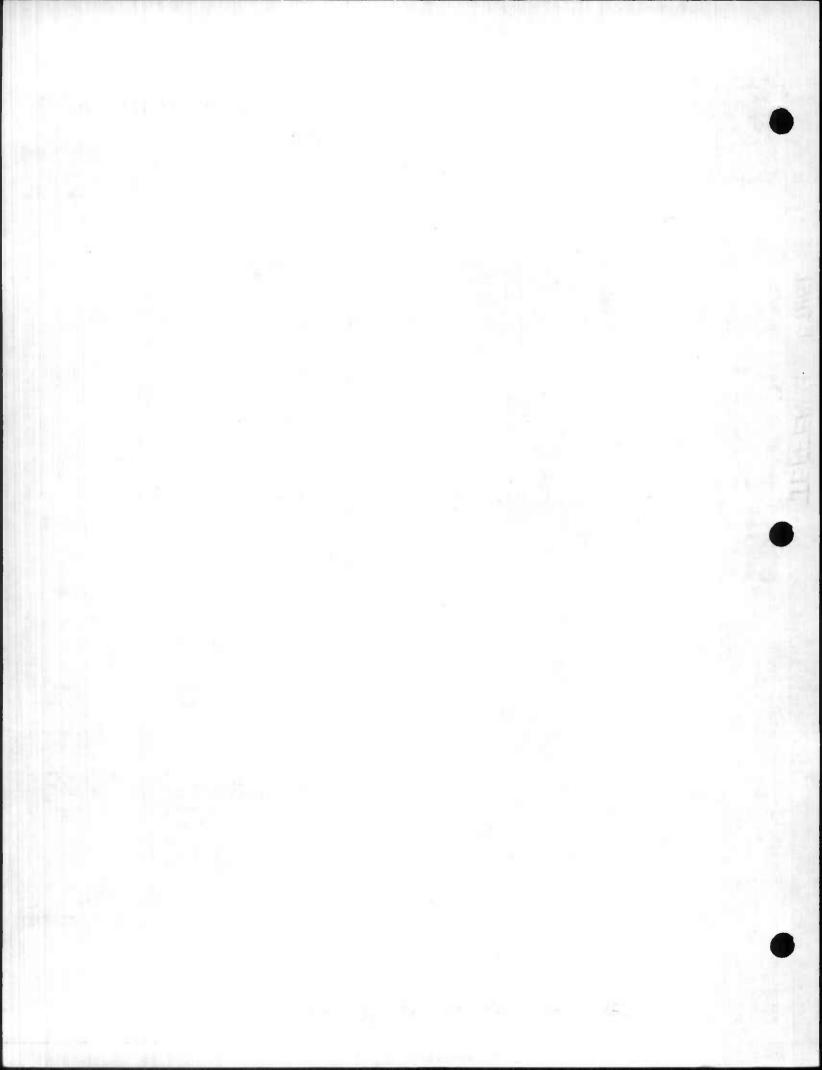


## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				i waiyiai	Се	rtificate	e of	lealth an Death	G IVIC		eg. No.	0.0	761
Physicial /Medica	_	1. Decedent's Name (First, Middle ELSIE I	, Last) JAN	ÆS						Month	Dey	Yeer	3. Time of Death 8 - 55 PM
Examine	r	4e. Fecility Neme (If not institution, CHARLESTOWN CAR		nber)				4b. City, Town, CATO				of Deeth BALTIM	ORE
uneral Director		578-12-5769	6. Sex 1 □ M 2/X F	7. Age (In yrs.	last birthday) 93 Yrs.	if Under Months	1 Year Deys	if Under 24 Hours	Hrs. 8	Date of Birth (Month, Day) 5/21/1	Year)	9. Birthpled Country MARY.	ce (State or Foreig /) LAND
a bow		Usual Residence of Decedent  10e. Stete 10b. County  MD E	BALTIMORE	10c. C	ity, Town or L	ocation		CATO	NSV]	ILLE		10d	I. Inside City Limits
23a or 28a-f ah	Director	10e. Street end Number 709 MAIDEN CHC	OICE LANE			10f. Zip	Code	21228		1	0g. Citizen of \	What Country	
of, or items Examiner m	by Funeral	11. Meritel Stetus  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Wes Dece Armed For 1 Tyes If Yes, Giv Yeer or De	rces? 2 <b>X</b> No e		Wes Deced		lispanic Origin an, Mexican, P Specify:	? (Speci uerto Ri	ify Yes or No- can, etc.)		ce - American ck, White, etc	0.
rygierie. rther than "nature!", ent, the Medical Ex-	Be Completed	15. Decedent' (Specify only highest Elementery/Secondary (0-12)	s Education grade completed) College (1	-4or 5+)	(Give	dent's Usue kind of won DO NOT us OMEMA	k done e retired	petion during most of d)	work/ng		16b. Kind of B	usiness/Indus	
tam 27 is marked other other traumatic event, I	lo Be	17. Fether's Neme (First, Middle, L ALBERT WALLIS									SANDERS		
and Information of the Informati	cal Examiner	MARY JAMES RADE  20e. Method of Disposition  Description   3 □ Removel from Secify)	State NE sussed the dee ach line.  Due to (	Plece of Disponential Plece of Disponential	solition (Namelony or of EDRAL)  2. Neme end 630 EI ter the mode  Only of equence of):	ce of the place of	SETERY SS of Fecility NDSON A	1/ WIT2 VE	/19/99 ZKE FUN CATONS	BALTIMERAL HOVILLE,	MORE, DMES, MD 21	n, State MD INC.	
hould be detached for use as	Clanyme	Part fl. Other significant condition	d	ath but not rea	sulting In the u	nderlying ca	use giv	ren in Pert I.		1 🗆 Y	e 2 No	3 Probel  24b. Were eveile comp of de	eutopsy findings able prior to pletion of cause
s certificata has t director, pege 2 s	0	25. Wes case referred to medical exeminer?	Hospitel:				_ Oth	05		Check only on	10)		, AD10
in the	erillication: 10	1   Yes 2   No  27. Menner of Death 1   Naturel 5   Pending 2   Accident   Investige 3   Sulcide 6   Could not determin	28a. Date of (Month) ation on the 28e. Piece	npatient 2 Injury h, Day Year) of injury - At hig, etc. (Speci	28b. Time o Injury	f 28	Bc. Injur Wor	PO_DIVUISII	28	d. Describe ho	ence 6 Oth ow injury occur treet and Numb o, State)	red	Route Number,
To the Funeral Director: After completely filled in by the funer completely filled in by the funeral Madical Cartification	edical	29e. Certifier (Check only one)  1S Certifying 2 ☐ Medical E  29b. Signeture and title of certifier	Physician: To the examiner: On the been menn	sis of examine	owledge, deat ation end/or in	vestigation,	in my o	pinion, deeth o	occurred	at the time, d	ete and place, 9d. Date signe	and due to the	ne cause(s)
V		30. Neme end address of person w	to completed cause	of deeth (Iter	n 23e) (Type,	O-I-A)		05			2/22		1789



			Certificate	e of Death	Reg.	No.99 0	0762
Physician	1. Decedent's Name (First, Middle, La	st)			2. Date of Death Month	Day Year	3. Time of Death
/Medical	ETHEL MAE	JEFFERSON			JANUARY	17, 1999	9:30Pm
Examiner	4a Facility Name (If not institution, giv MERCY HOSPICE	e street and number)		4b. City, Town, or U BALTIMORI		4c. County of Dea	th
Funeral Director	5. Social Security Number 6. S 250–18–6192	ex 7. Age (In yrs. 75	last birthday) If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	(Month, Day, Yo	ear) 9. Bir	thplaca (State or Foreign ountry) H CAROLINA
	Usual Residence of Decedent						
with the Manyland a or 28s-f ahow be notified at	10a. Stete 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
vith the Ma or 28a-f a be notified Director	MARYLAND N/A		BALTIMORI 10f. Zip		100	. Citizen of What Co	X
Name of the state	2305 O"DELL AVEN	IUE	101. 2.5	21237		U.S.	
ther death v cheme 23 other ment	11. Meritel Status	12. Was Decedent Ever in U Armed Forces?	S. 13. Wes Deced	ent of Hispanic Origin? (Spirity Cuben, Mexican, Puert	pecify Yes or No-	14. Raca - Ame Bleck, Whit	erican Indian,
4/E	1 Never Merried 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give X Yeer or Dates:	1 □ Yes 2		o riican, etc.,	Specify:	S.A.
121215-0 ed within 72 ho sygiene. The Medical completed	15. Decedent's Ed	lucation de completed)	16a. Decedent's Usua (Give kind of wor	k done during most of wor	king 16	b. Kind of Business	/Industry
TO Men no man no	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT us	e retired)		TA OTTODAY	
d 2.	17. Father's Name (First, Middle, Last)	N/A	PACKER	18 Mother's Nen	ne (First, Middle, Mai	ACTORY	
and dbe find the find the find of the find							
SO Should anyla Manke	19a. Informant's Name/Relationship (	Type, Print)	19b. Melling Address	MATTIE (Street and Number or Ru		ity or Town, State,	Zip Code)
TERSON, E. Maryland 212.  Te, Maryland 212.  A Health and Mental Hygiene.  Ham 27 is marked other than other traumatic event, the M.  To Be Compi	NETTIE HARVEY /		4 Serpens	Ct. Balto, M	/d. 21213		
ore, Maryland ore, Maryland of Health and Mental to the train and Mental to the train and Mental to the train and tr	20a. Method of Disposition		Place of Disposition (Name	ne of ther place)	Date 20	c. Location - City or	Town, State
im im Pege	1 Buriel 2 Cremetion 3 4 Donation 5 Other (Specify	Removel from State		REMATORY JAN	. 19, 1999	BALTO, I	MD.
Baltimore, Maryland 212. Baltimore, Maryland 212. pemir. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than enty injury or other traumatic event, the single-	21. Signature of Funeral Service Licer	2	CALVIN	d Address of Facility  B. SCRUGGS			
1 0	23a. Part1. Enter the disease, or com shock, or heert teilure. List only	plications that caused the deal	1412 F	E. PRESTON ST	or respiratory arrest	D. 2121	Approximate
Physician	shock, or heert teilure. List only	one cause on each line.					Interval Between Onset and Deeth
/Medical	Immediate Cause (Final disease or condition		methythe	colon ca	NUT		
Examiner	resulting in death)		or as a consequence of):				
A P E E							
58760, cate be executed physician and sub-bunst-transit	Sequentially list conditions,	Due to (d	or as a consequence of):				
	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c					
68760, rificate be a physician as the buria	that initiated events resulting in death) Last	Due to (o	or es a consequence of):				
		d					
P.O. Box at the death cert 1 by the attending etached for use of	Part II. Other eignificant conditions o	patributing to death but not res	ulting in the underlying o	ouse sines is Bart I	23h Did tohe	eco una contribut	te to the cause of death?
P.O. at the dat the dat the dat the dat the datached	Part II. Other eigninicant conditions of	ontributing to death but not res	oning in the underlying a	ause given in Fait i.			Probably 4 Unknown
EXT							
Division of Vital Records, P.O. Box of or Attending Physician: The law requires that tha death certain of the constitution on tificate has been signed by the attending in by the funeral director, page 2 should be detached for use ertification: To Be Completed by PhysicianA					24a. Was an a		Were autopsy findings available prior to
Il Record The law require page 2 should Completed							completion of cause of death?
Vital Reu lician: The lav certificate has irector, page 2	Station and the state of				1 ☐ Yes	28 No -	1 Yes 2 No
Vita iclan: sector	25. Was case referred to medical axaminer?	Hospital:		Othor	eth (Check only one)		DIS AT MEACY
Of Notice of this of rail directions: To	1 Yes 2 No 27, Manner of Death	1 L Inpatient 2 L		A 4 Norsing H	ome 5 Residence 28d. Describe how		ecity) HOSPICE
On On Oh	1 Abaturel 5 Pending	28a. Date of Injury (Month, Day Year)	Injury	8c. tnjury at Work? 1   Yes 2   No	200.00000000000	injury cocairon	
Division of Vita to a stranding Physician: a street death. It of Director. After this centificiation by the funeral director. Certification: To Be (	3 Suicide 6 Could not b	28e. Plece of Injury - At h	ome, farm, street, fectory	, office	28f. Location (Street	et and Number or F	Rural Route Number,
Diversity of the Control of the Cont	4 Homicide	building, etc. (Special	( <del>y</del> )		City or Town,	Stare)	
Division of Vital Reventing Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29e. Certifier Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my knoniner: On the basis of examina and manner stated.	ewledge, death occurred ation and/or investigation,	at the time, date and place In my opinion, deeth occu	, end due to the causered at the time, date	se(s) and manner a e end pleca, and du	is stated. le to the cause(s)
outh ompl	29b. Signeture and fittle of certifier		290	. License number	29d	. Date signed (Mon	nth, Day, Year)
	> Hel Ch	on (		D4085	1	1/1	8/49
	30. Neme and eddress of person who	completed cause of death (Iter	n 23a) (Type, Print)	.0			1
	-		77 301 St	Poul Pl 13n1	time 212	2 2	
State	31. Date filed (Month, Day, Year)	32. Registrar's Signe	eture 4				
Registrar	JAN 1 9 199	55	19. AO	De Nal			



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth JONES JOSEPHINE 18 07:15AM JANUARY 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Sociel Security Number Birthplece (State or Foreign Country) 1 □ M 2 🗗 F Deys 212 44 8232 Jan. 17,1939 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland Baltimore Essex 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1401 Old Eastern Ave. "Apt 4" 21221 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Merital Stetus Bleck, White, etc. 1 Never Married 2 X Merried 1 Tyes 2 No Specify White Specify. 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Lawrence Wilev Josephine Dimler 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 1401 Old Eastern Ave. "Apt 4" Balto., Md. 21221 (Husband) Richard Jones 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State Greenmount Crematory 1/21/1999 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signet to of Auneral Service Licen Bruzdzinski Funeral Home P.A. 23a. P.m. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, not k, or heart feilure. List only one cause on each line. 1407 Old Eastern Avenue Essex, Approximete Intervei Between Onset and Death immediate Cause (Final disease or condition resulting in deeth) 1 MONTH HEPATIC FAILURE Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ★inpatient 2 □ ER/Outpetient 3 □ DOA 28d. Describe how Injury occurred 28h Time of

physician and s the burial-transit law requires that the death certificata be executed Division of Vital Records, P.O. Box 68760, attending ph for usa as t signed by the a

certificate has t irector, page 2 s I or Attending Physician: after death. Director: After this certifica director, funeral To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by th

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

r 28a-f ahow

7 is marked other than "natural", or flams 23a or traumatic event, the Medical Examiner must be

Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mental hygiene. Int: If them 27 Is marked other than "natural", or flar Inty or other traumatic event, the Mental Engine.

permit. Page Department of Important: If any Injury or page.

**Physician** /Medicai

Examiner

Examiner

Physician/Medical

P

Completed

Be

Certification: To

Medical

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

death with the Maryland

RENAL FAILURE, METABOLIC ACIDOSIS, COAGULOPATHY 25. Wes case referred to medical exeminer? 1 Yes 2 No 28a. Dete of injury (Month, Dey Year) 28c. Injury et Work? 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

27. Menner of Deeth 1 Neturel 2 Accident 3 Suicide

281. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a, Certifier (Check only one)

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and pieca, and due to the cause(s) and menner stated.

29b. Signature and title of cartified

29c. License number

29d. Date signed (Month, Dey, Year)

MD 48Vm

97023

JANUARY 18, 1999

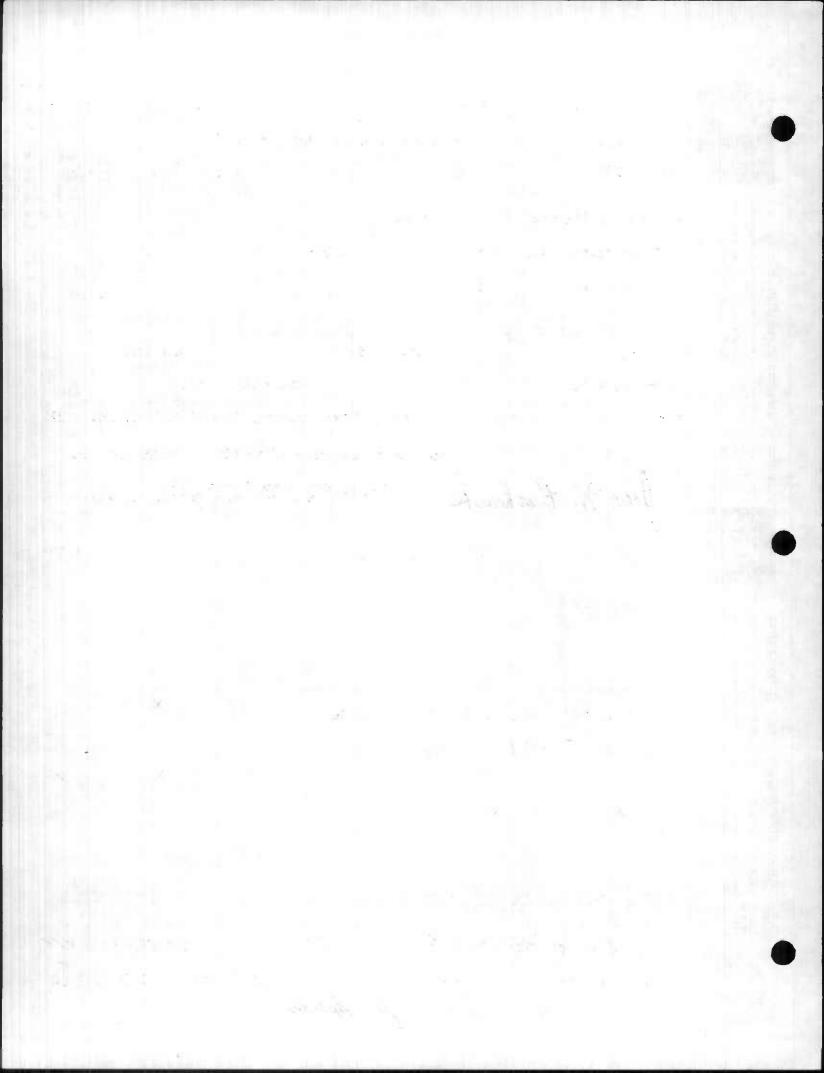
30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

VICTORIA BALTIMORE MARYLAND 21224 PORTER MD 4940 EASTERN 31. Dete filed (Month, Day, Yeer)

State Registrar

32. Registra 's Signature JAN 1 9 1999 >

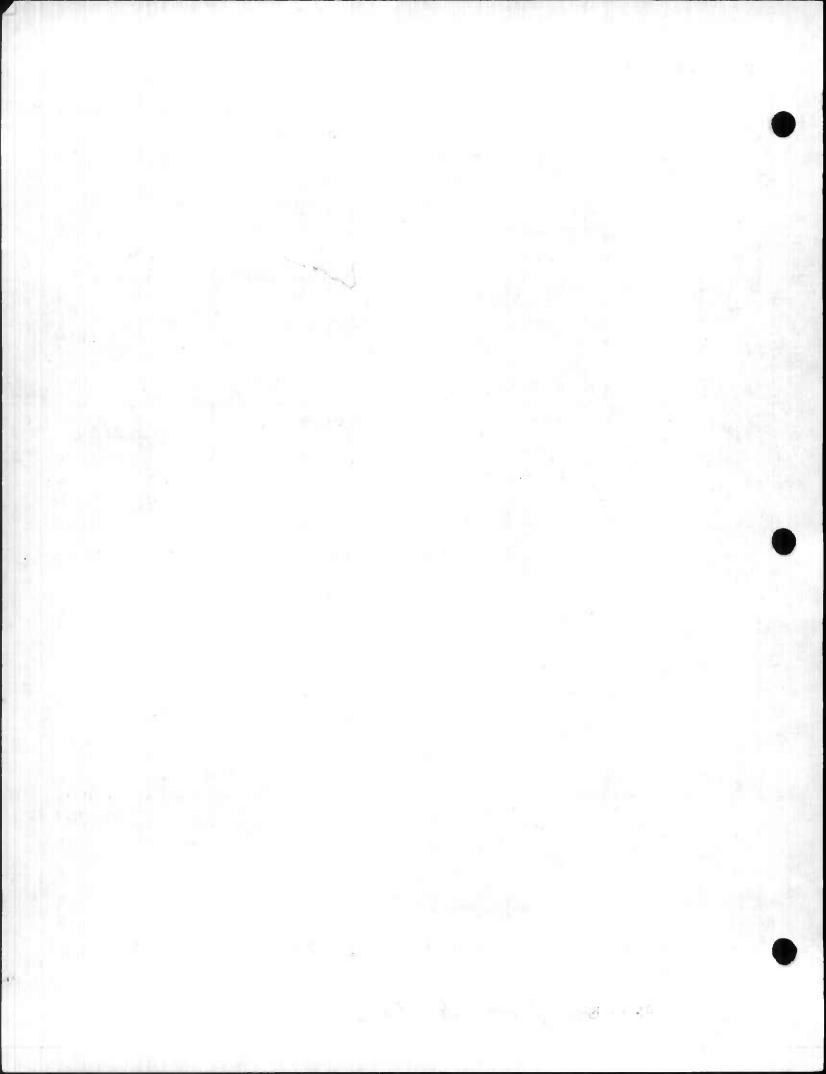
oaks



State Registrar 31. Date filed (Month, Day, Year) JAN 1 9 1999 Server B.

Sparks

sara Anne



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer Kellx **Physician** Jose Mine 13.1999 4c. County of Deal Jenuar /Medical 4a Facility Name (If not institution, give street and numbers of Liberty Meight 4b. City, Town, or Location of Deetl Examiner sberty Metical Center BALTIMORE BATIMORZ MD 21315 If Under 24 Hrs. 9/Birthpleca (State or Foreign 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Houra 1□ M 20 F 214-24-3769 Usuel Residence of Decedent Yrs. **Director** filed within 72 hours eftar deeth with the Maryland permit. Pages 1 and 2 should be filed within 72 hours eftar deeth with the Marylan Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Eventor must be notified an once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limita 1 NYes 2 No Directo Mary and 10e. Street end Number mor 10f. Zip Code 10g. Citizen of Whet Country? 21 2 9 Funeral 14. Rece - American Indian Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 Never Married 2 Merried 2 X No altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 N Widowed 4 □ Divorced Yeer or Detes Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) etician 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) (Son) 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) agt. 810 A Md. 21215 0. awin 10 20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca) Dete 20c. Location - City or Town, Stete 20a. Method of Disposition /18/99 1 

■ Burial 2 □ Cremetion 3 □ Removel from State 4 Donetion 5 □ Other (Specify) 21. Signeture of Funerel Servige Licansee 22. Name end Address of Facility Joseph 22221 Ru Honz 5 y North Ave. Md. 21216 ations that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory occuse on each line. Approximete Intervel Between Onset end Deeth sease, or compli **Physician** /Medical Immediete Ceuse (Finel iRATion neu morica diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Physician/Medical Examiner Wsufficiency ed by the attending physician and detached for use as the bunal-transit The lew requires that the death certificate be axecuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury Due to (or es e conseque nca of) thet initieted eventa resulting in deeth) Lest Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by Carolio vasandar Division of Vital Records. Completed by certificate has been signi rector, page 2 should be 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Was en eutopsy performed? Calemia . Decubitus ulcars 1 Yea 2 No 1 ☐ Yes 2 No Physician: Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) 1 ☐ Yes 2 ☐ No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpetient 3 DOA 2 within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral di 28e. Date of Injury (Month, Dey Yeer) 27. Manner of Deeth 28c. injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending Investigation or Attending 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceuse(s) end menner as stated.
2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner steted. edical 29a. Certifier (Check only 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) person who completed cause of deeth (Item 23a) (Type, Print) 2600 Liberty

32. Registra & Signeture

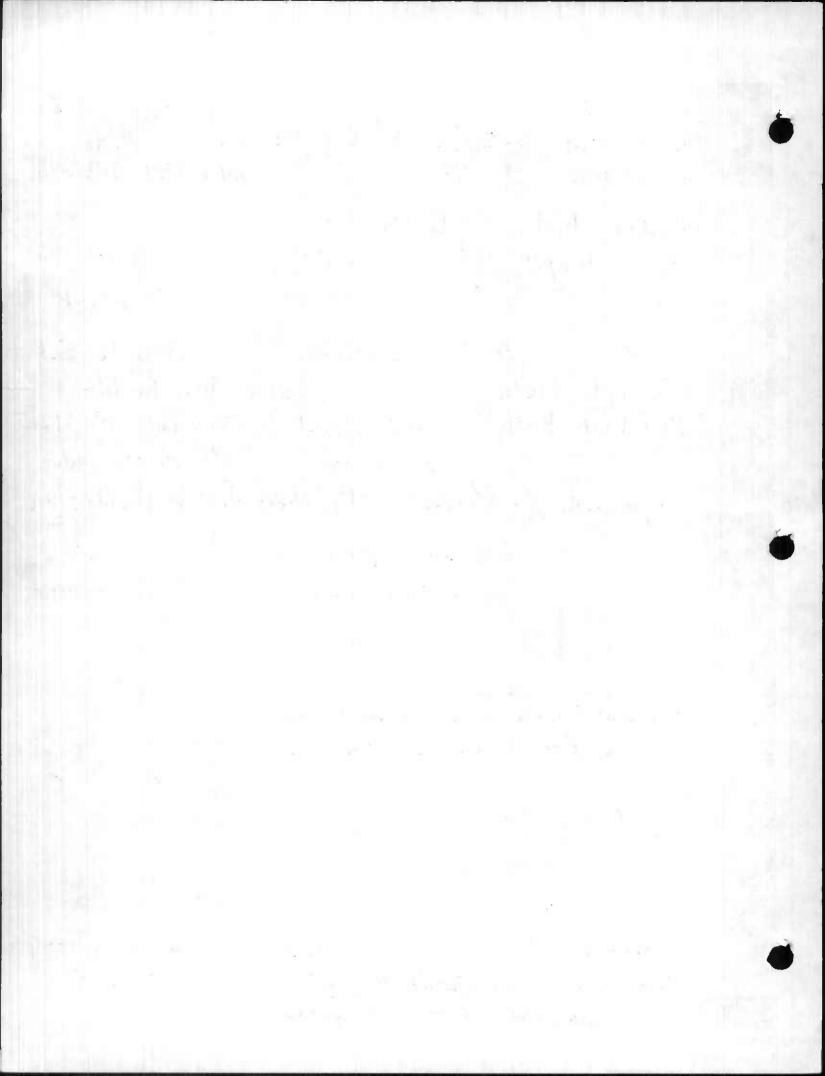
9 1999

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Yaar 1999 JAN 10 1:55 PM JOSEPH WILLIAM KOLOMAZNIK 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Dealt Deaton Medical Center Baltimore N/A If Undar 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplece (Stata or Foraign Country) 10XM 20 F Months Days Hours Min 72 Yrs. 219-10-2323 March 5,1926 Maryland Usual Rasidanca of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. fnsida City Limits Maryland Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 8428 Forest Drive 21122 United States 12. Was Decedeni Ever in U.S. Armed Forcas? 1 (X Yes 2 □ No If Yas, Give 0 43-1949 Year or Dates 43-1949 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Biack, Whita, atc. 1 Navar Marriad 2 Marriad 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry 16a. Decedant's Usuel Occupation (Giva kind of work dona duning most of working lifa. DO NOT usa ratired) College (1-4or 5+) N/A Elementery/Secondary (0-12) Tool Die Maker Western Electric 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Falher's Nama (First, Middle, Last) Joseph Kolomaznik Margaret Kempf 19a. Informant's Name/Ralationship (Type, Print) 19b. Melling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Charlotte V. Kolomaznik Wife 8428 Forest Drive Pasadena, Maryland 21122 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1X Burial 2 ☐ Cramation 3 ☐ Removal from Stata Meadowridge Mem. Park Jan. 20, 1999 Elkridge, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Se 22. Nama and Addrass of Facility
McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Part1. Enter the disease, or comp shock, or heap failure. List only ications thet causad the death. Do not enter tha moda of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Death Immediata Causa (Final diseasa or condition resulting in deeth) 3 mml Capcinoma LUNU Due to (or as e consequence of): SpIne dmns Concer 10 metastate Lvny Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Disaasa or Injury Ihat Initiatad evants resulting in deeth) Last Due to (or as a consequence of) 1 monm venhlator depandent of opplieter terime Dua to to 154-8 chsmone 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings evelleble prior to completion of causa 24a. Was an autopsy performed? of death? 1 ☐ Yes 2 No 1 Yas 2 No 25. Wes case rafarred to medical axaminar? 26. Placa of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No 1 PInpatient 2 □ ER/Outpatient 3 □ DOA 27. Mannet of Deeth 28a. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 (Natural 5 Pending 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 6 Could not be detarmined 3 Suicida 28a. Pleca of Injury - Al home, farm, streat, factory, office building, etc. (Spacify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

requires that the death certificate be executed P.O. Box 68760 Me!

Examiner Physician/Medicai 80 attending esn Po ed by the a signed t þ should t Completed page 2 s 285 certificate or Attending Physician: Be 10 this funeral After death.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ehow. r 28a-f show

Examiner must be r

Pages 1 and 2 should be tiled within 72 hours after death and Mental Hygiene.
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**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0020

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Funeral

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Records,

Certification: within 24 hours after death To the Funerel Director:, completely filled in by the Hospital edicai X

> State Registrar

29b. Signature and title of certifier

4 ☐ Homicide

(Check only one)

29a. Certifiar

29c. Licansa number 030494

2 Medical Examiner: On the basis of axemination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 1/17/1999

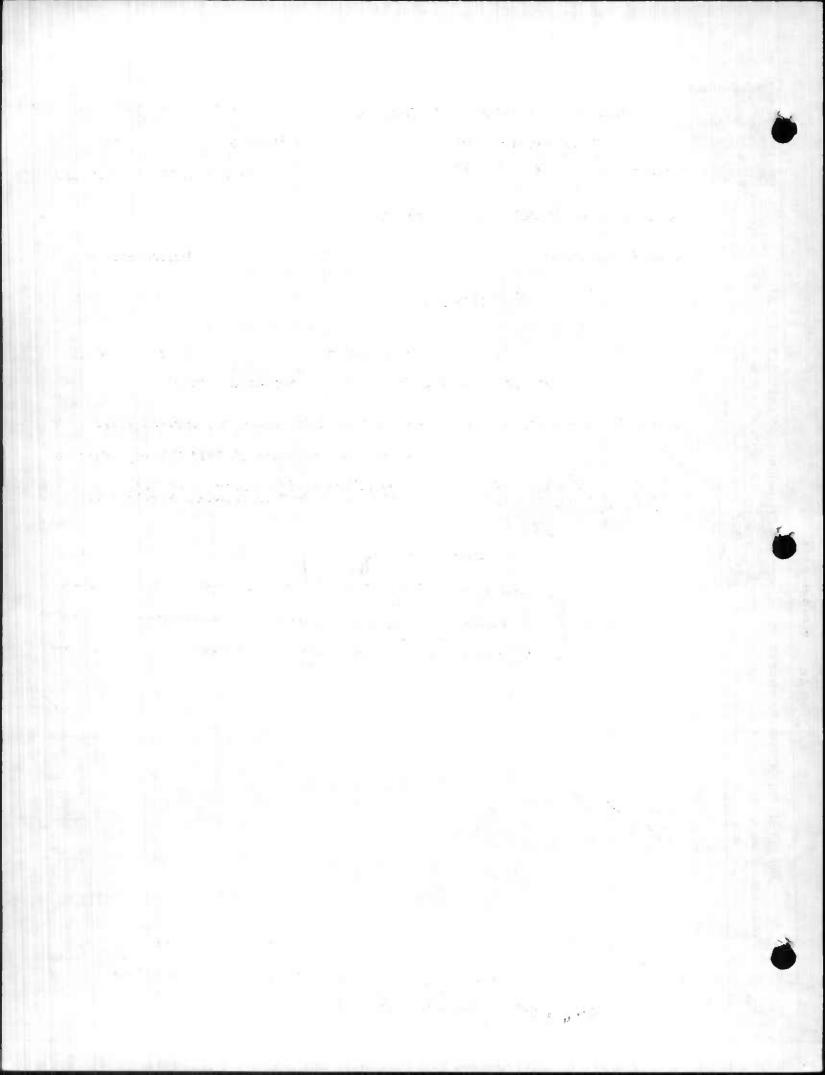
30. Nembered addrass of person who completed cause of deeth (Item 23a) (Type, Print)

KOESHIMD Death Medical Center GII South Charles St Baltmar up al250

32. Registar's Signature 31. Data filed (Month, Day, Year) JAN 1 9 1999

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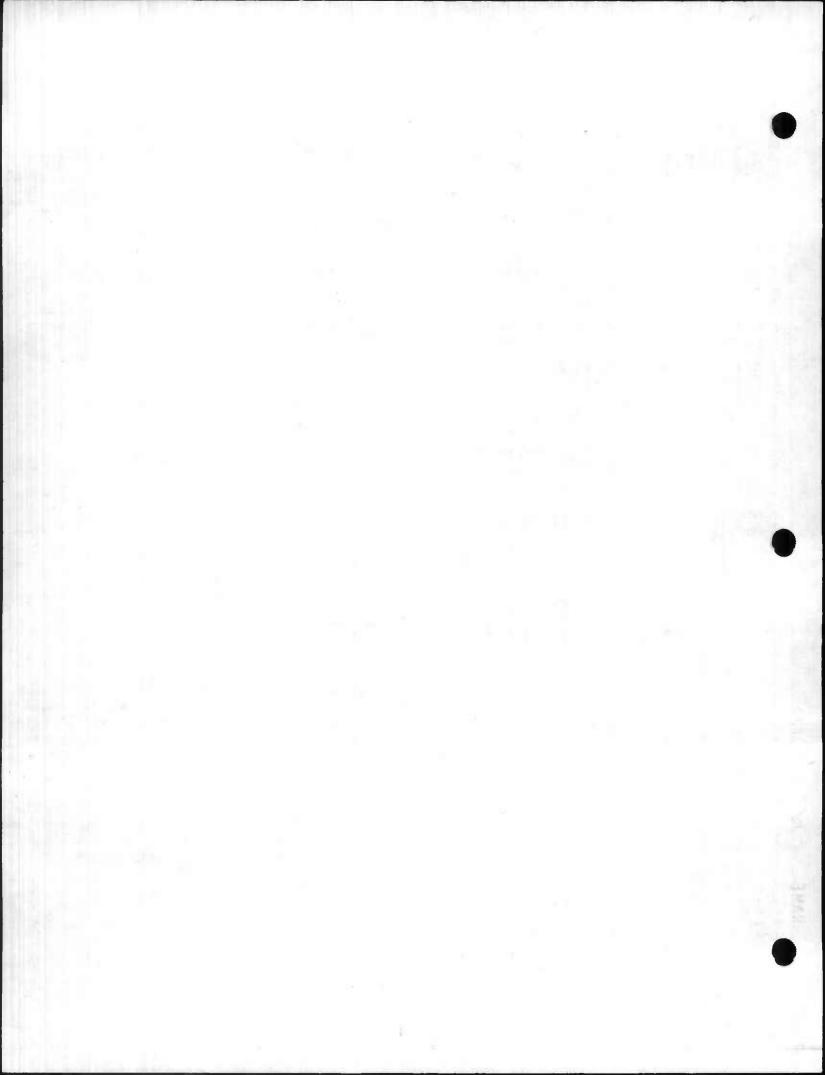
1 🗹 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 0757

Physician	1. Decedent's Na	and the same of							2. Date of Month	Death Day	Year	3. Tima of Death
/Medical	EON.	4 4	Kon	VTZ	-				Jan	17	1999	0830
Examiner	4a Facility Name	(If not institution, given	re street and numbe	r)				4b. City, Town,	or Location of De	ath 4c. Cou	nty of Death	1
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Funeral	5. Social Security			Age (In yrs.	last birthday	y) If Under Months	1 Year	If Under 24 F	Irs. 8. Date of I			nplace (State or Foreig
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wor m	10a. State	10b. County		10c. Cit	ly, Town or I	Location						10d. Inside City Limit
or 28a-f show or notified at Director	MD	Balti	moro	C	atana	svill	•					1 ☐ Yes X☐ N
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yd by		rried 2 ☐ Married 4 ☐ Divorced	1 ☐ Yes ②C If Yes, Give Year or Dates	No :		1□ Yes	2EXNo	Specify:		Spe	city: Whi	te
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permit. Pages 1 an Department of Heal Important: if item 2 any Injury or other page.	1	ele d	111			MacN	abb	Funer	al Home	P.A.		
		ard A.	regerch			301	Fre	derick	Rd. Ba	ltimo	ce. M	ID 21228
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** PEARL LOUISE KNELL JAN /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MARINER HEALTH OF BEL AIR BEL AIR HARFORD If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 4/13/1905 5. Social Security Number 214-18-1706 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** Days 1 M 20 F 93 Yrs. Director PENNSYLVANIA Usual Rasidance of Decedant 10a Stata 10b. Counts 10c. City, Town or Location 10d. tnsida City Limits 7 is marked other than "natural", or llame 23s or 28s-f show traumatic event, the Medical Examiner must be notified at the Maryla MD BALTIMORE BALTIMORE MYas 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 820 CATON AVENUE 21229 U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal.
Department of Health and Mental Hygiens.
Important if flem 27 is marked other than any injury or other traumetic 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yaa or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - American Indian. Biack, Whita, atc. 1 Yaa 2 No If Yas, Giva Yaar or Datas: 1 ☐ Navar Married 2 ☐ Married 1 Yas 2 No Specify: À Specify: 3 XWidowed 4 □ Divorced WHITE Completed 15. Decedant's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working life. DO NOT use retired) (Specify only highast grada complated) Elamentary/Secondary (0-12) College (1-4or 5+) HAIRDRESSER OWN BUSINESS 17. Father's Name (First Middle Last) 18. Mother'a Nama (First, Middle, Maiden Sumame) Be HENRY KLINEDINST MARY (LAUER) 0 19a. Informant's Name/Raletionship (Type, Print) 19b. Melling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) SUSAN LAUTZ (NEICE) 1308 BENNETT PLACE BEL AIR, MD 21015 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) NEW CATHEDRAL CEMETERY 1/16/99 BALTIMORE CITY, MD e of Funeral Service L'a 22. Nama and Address of Facility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVE CATONSVILLE, MD 21228 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medicai Immedieta Causa (Final Pheamonia diseasa or condition rasulting in death) **Examiner** Dua to (or as e consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, laeding to immadiate cause. Enter Underlying Cause (Disasse or injury that initiated evants resulting in death) Last Due to (or as a consequence of) sate has been signed by the ettending physician, page 2 should be detached for use as the burla Physician/Medical Dua to (or as a consequence of) Part II. Other etgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 Probably 4 Unknown by 24b. Ware sutopsy findinga available prior to Completed 24a. Was an autopsy performed? completion of cause 1 Yas 2 No After this certificate 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical Be 26. Place of Death (Check only ona) Othar: Nursing Homa 5 Rasidence 6 Othar (Specify) P 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how Injury occurred Certification: 5 Panding invastigation 1 Natural death. 1 Yas 2 No 2 Accident filled in by the Director: 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) or A 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is 15/Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.
2/ Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, data and piece, and dua to the cause(s) and mannar stated. 29a. Certifian Medical 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year)

State Registrar filed (Month, Day, Year) 32. Ragistrar's Signatura

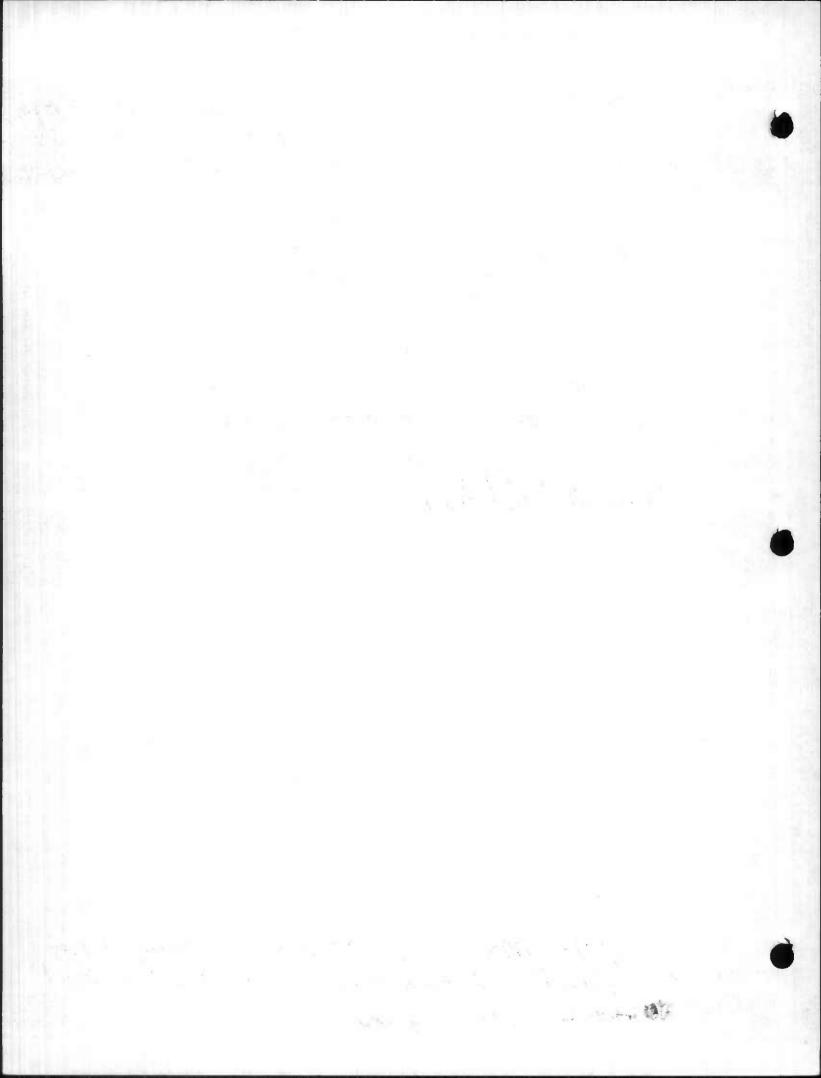
HAS

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

North

Avenu1

DHMH 16 Ray 6/95



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death

**Physician** /Medical Examiner

**Funeral** 

Director

Completed by Funeral

Be

Director rai", or items 23a or 28a-f show traumatic event, the Medical marked other than Pages 1 and 2 should be nent of Haalth and Mental

ELLNER

**Physician** /Medicai Examiner

Haalth 8

Baltimore,

other

or other

Department of important: If any Injury or

Examiner The law requires that the death certificate be executed Physician/Medical USB BS be datached page 2 certificate this funeral After

P.O.

Division of Vital Records,

or Attending Physician: death. s after death In by 24 hours a Hospital completaly To the within 2

1. Decedent's Name (First, Middle, Lest) VANUXRY 16 1999 Dolores C. Kellner 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death ARUNDEL HOSPITAL BLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. Now onth Pay, Year 911 5. Social Security Number 7. Age (In yrs. lest birthday) 1□ M 2□ F 217-58-5640 87 MaryTand Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8042 Bosley Court 21061 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give ¾ Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedeni of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 Ho Specify: 3 ™ Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Henry Huber Sophie Schmidt 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Evelyn Kellner/Daughter 8042 Bosley Court Glen Burnie, MD 21061 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Jan.19, Sykesville, MD Lakeview Mem. Park 4 ☐ Donalion 5 ☐ Other (Specify) 1999 21. Signature duneral Service Licensee 22. Name end Address of Fecility Kirkley-Ruddick Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approx. Shock, or heart failure. List only one cause on each line. Immediate Ceuse (Finel SBRS15 disease or condition resulting in death) Due to (or as e consequence of): MULTI INFARCT DEMENTIA Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): TROTHY POINTSM Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Completed by 24b. Were eutopsy findings aveileble prior to completion of ceuse of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. edical (Check only one) 2 Medical Examinar: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

JAN 191999

29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

4.32 Am

10d. inside City Limits

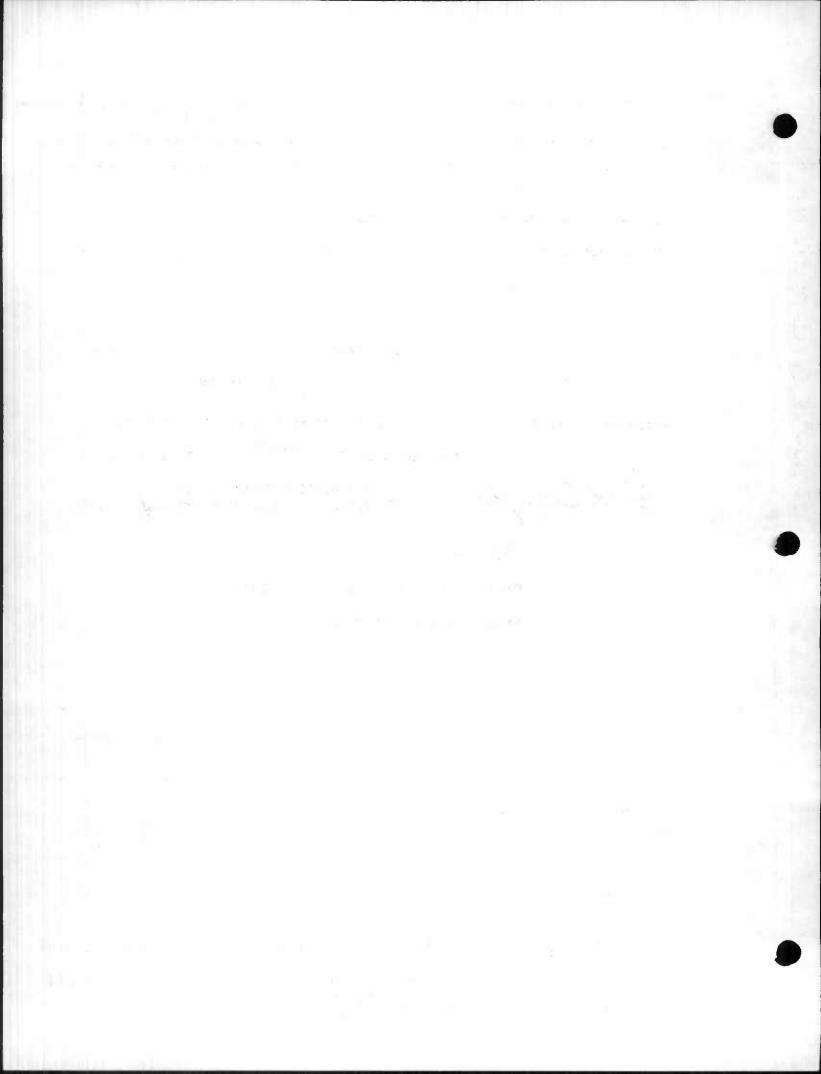
Approximate Interval Between Onset and Death

1 ☐ Yes 2√ No

30. Name end endress of person who completed cause of deeth (Item 23e) (Type, Print)

ALE GLEN BURNIE 31. Dete filed (Month, Dey, Year)

State Registrar Sz. P gistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** Marie 2:30 Pm January 13, 1999 /Medical 4a. Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ospital Samarit an Baltimore If Under 1 Year If Under 24 Hrs.
Months Devs Hours Min. 6. Sex 1 M 2□ F 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Dete of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** Deys Yrs. Director 216 07 5526 Dec. 9, 1913 Maryland Usual Residence of Decedent the Marylend 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò Items 23a 3112 Louise Avenue 21214 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ Specify: 3 Widowed 4 □ Divorced Completed 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiamentery/Sacondery (0-12) College (1-4or 5+) Housewife Own Home 17. Fether's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middla, Meldan Surnama) Be Mathew Piekarski Alexandra Zalewski 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) permit. Peges 1 end 2: Department of Health er Important: If Item 27 is any injury or other trau George Kurgan Jr. (Son) 3112 Louise Ave. Baltimore, Md. 21214 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Holy Rosary Cemetery 1/16/1999 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Bruzdzinski Funeral Home P.A. I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart feilura. List only one ceuse on each line. 1407 Old Eastern Avenue Essex, Md. 21221 Approximete Interval Between Onset and Deeth **Physician** CardioPul monagarrest 20 minutes /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or es e consequance of): ensis physicien end s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Entar Underlying Cause (Diseese or Injury that initiated avants resulting in deeth) Lest sepsis alsen P.O. Box 68760. Physician/Medical Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 □ Probably 4 ☑ Unknown 1 Yes 2 No Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen page 2 s 2 100 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes cesa referred to medical Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dinpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28e. Dete of injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 26d. Dascribe how injury occurred After death. 1 Natural 5 Pending investigation 1 Yas 2 No 2 Accidant 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 28e. Plece of Injury - At home, ferm, streat, fectory, office building, atc. (Specify) 4 Homicide 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end menner es stetad.
2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the ceuse(s) and menner steted. 29e. Certifier 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar

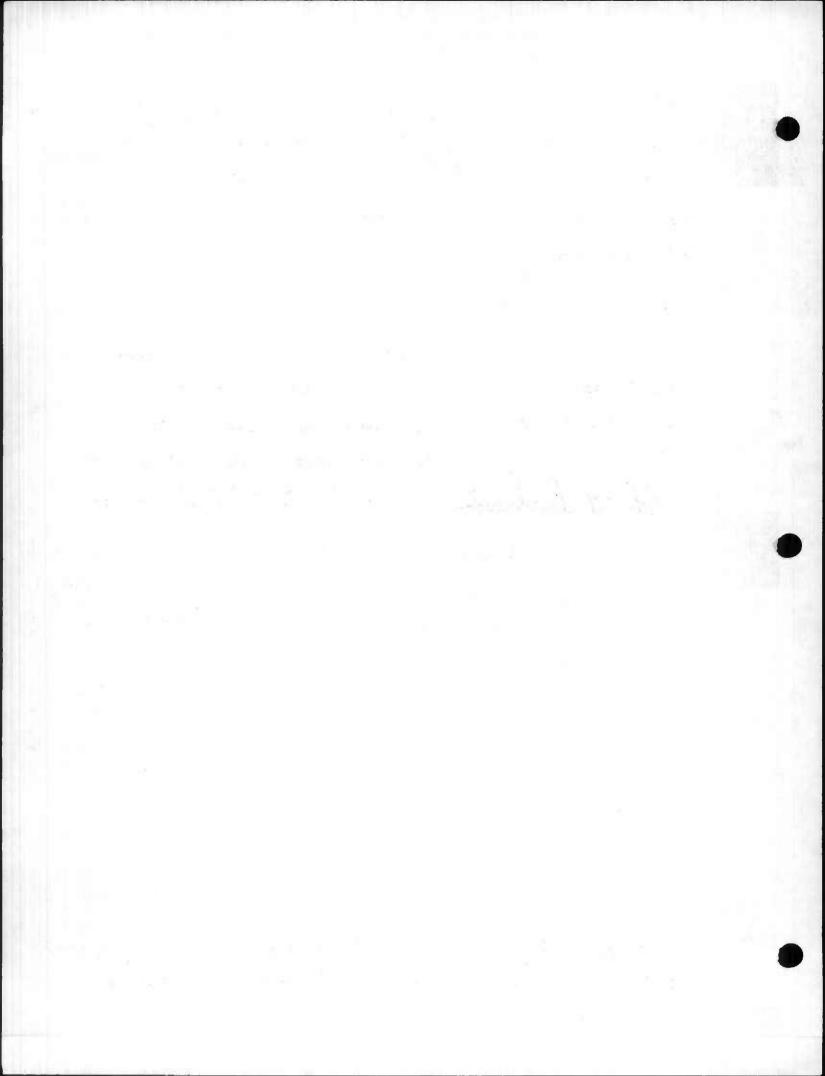
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9

31. Date filed (Month, Dey, Year) JAN 1 9 1999

32. Registrar's Signeture

30. Nema and address of person who complated cause of death (Item 23a) (Type, Print) 5 6 0 1 6 Ch Kaven 30 VI e Value Soulevard, Baltimore Magland 2/231



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** 1:30 PM RANK KATALINICK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) **Examiner** MEDICAL DAYVIEW JOHNS HOPKINS If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 10M 20F Days Hours Min. 217-20-6381 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Tes 2 No MID BALTIMORE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5301 21206 USA Funerai MUENUE 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Biack, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1□ Yes 2™No Specify: Specity: WHITE þ 3 Widowed 4 Divorced 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BARBER SELF 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Be UNKNOWN UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 3301 CEDERHURST 21206 KATALINICK MRS. MARY 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State 1-12.99 BALTO, MI 4 ☐ Donetion 5 ☐ Other (Specify) TANISLAUS 22. Name and Address of Fecility KAC TOROWSKI FUNEAM 21. Signature of Funeral Service Licensee Ancles 25.25 FLEET ST. BALTO. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. BALTO. Approximate Interval Between Onset and Deeth Immediate Ceuse (Finel disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injuried events.) orona thet initieted events resulting in death) Last Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 2 Unknown VIMERAI þ 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 281 No 1 Yes 20 No Kena 25. Was case referred to medica exeminer? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturei 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

certificate be executed P.O. Box 68760 Division of Vital Records. or Attanding after death. 24 hours Hospital

**Funeral** 

**Director** 

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Hygiene.

. Pages 1 and 2 should be fit iment of Health and Mental H lant; If item 27 is marked out

permit. Pages 1 and 2.
Department of Health a Important: If Item 27 is any Injury or other traconce.

**Physician** 

/Medical **Examiner** 

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signed by the a

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After

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other traumatic avent.

Baltimore, Maryland 21215-0020

Registrar

State

Medical

29a, Certifier

29b. Signeture end title of certifier

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29c. License number

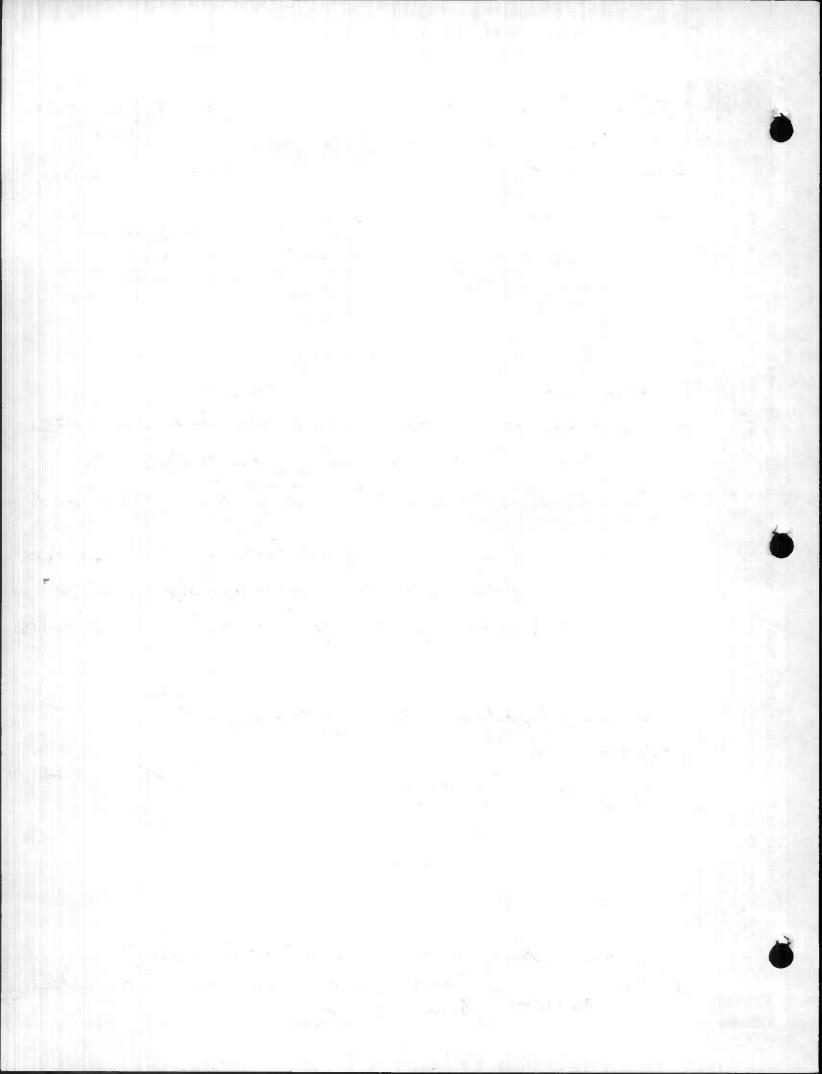
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Ku TIMA 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

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31. Dete filed (Month, DEAN 32. Registra/s Signature 9 1999



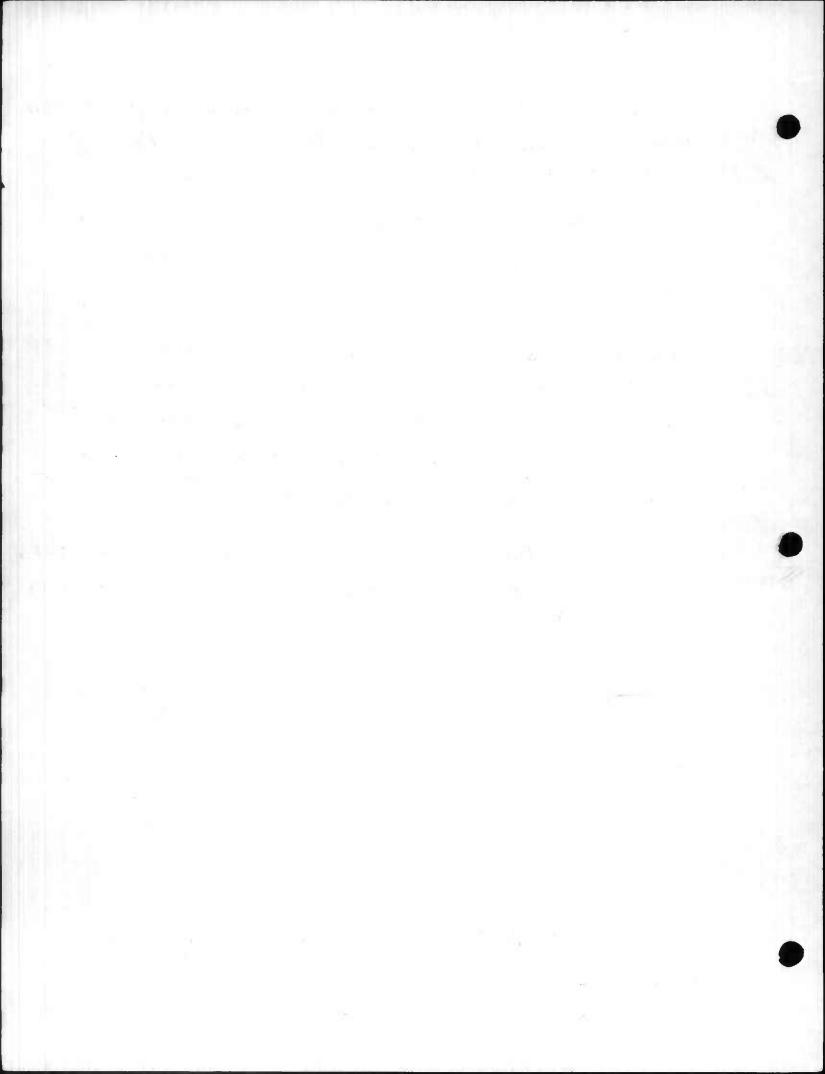
State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:33 PM INTONIO 1999 ANCE JANUARY /Medicai Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARYLAND MEDICAL DYSTEMS BALTIMORE If Under 24 Hrs. 8. Date UNIVERSITY OF 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) ₩ 2□ F Months Days Hours Min 219-27-8560 11 Yrs **Director** 04-05-87 MD Usual Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shr r mast be nothed a 1 Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 630 Melville Avenue 21218 USA by Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married 21215-0020 ŏ 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Black "natural" Completed The Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Student Student 6th Grade Child traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Pages 1 end 2 should be inent of Health end Mental I int: if Item 27 is marked of Andre Nichelle Lance Neely 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 Department of Health er Important: if Item 27 is any injury or other tra-Nichelle Neely 630 Melville Avenue Baltimore, Maryland 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Cemetery 01-20-99 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or comblications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical MULTIPLE Immediete Cause (Finel HOURS disease or condition resulting in death) Éxaminer HOURS EVERE ANEMIA The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last and burial-tran Due to (or as e consequence of) Box 68760, physician Physician/Medical the Due to (or as e consequence of) esn for signed by the er Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? certificate 2 No 1 Yes 2 No or Attanding Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending 1 Yes 2 No deeth investigation efter deeth the 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homleide completely filled 24 hours Hospital 29a. Certifier 🗶 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. To the Within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SOUTH BACTIMORE MARYLAND 21201

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State Registrar

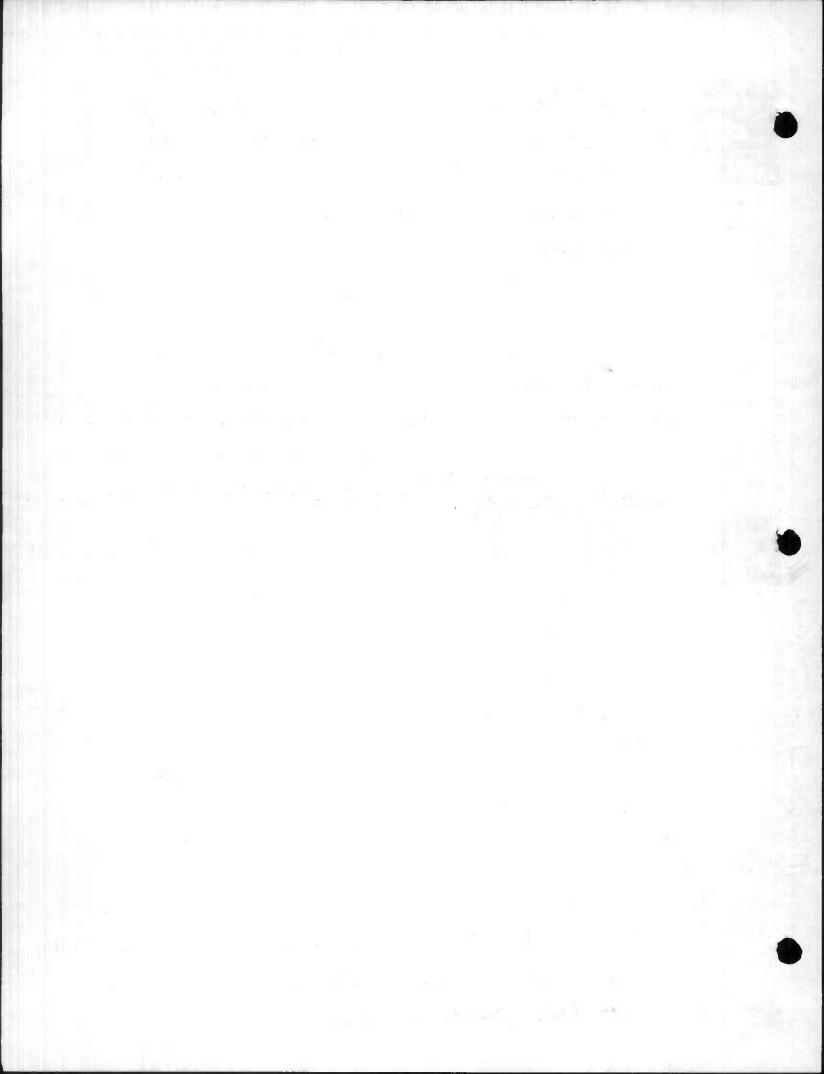
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		30. Nama and add	s of person who	complated caus	sa of death (Iter	m 23a) (Type,			on So	luer	o TT			
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State Registrar

Sparker



**Physician** /Medical Examiner

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or Attanding Physician: The law requiras that the death certificate be executed

After this

24 hours after death. Funeral Director: A

within 24 hor To the Fune completaly fi

To the Hospital

filled in by

Records, P.O. Box 68760,

Division of Vital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

rai", or items 23s or 28s-f shore Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hygiena.
Important: If item 27 is marked other than "natural", or iter any injury or other traumatic avent, the Medical Exemples once.

Baltimore, Maryland 21215-0020

Director

Funerai

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Examiner Physician/Medical Completed by Be edical Certification: To

25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work?

27. Mannar of Death 5 Pending invastigation 1. Natural 2 Accidant 6 Could not be datermined 3 ☐ Suicida

28a. Data of Injury (Month, Day Year)

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28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifiar (Check only one)

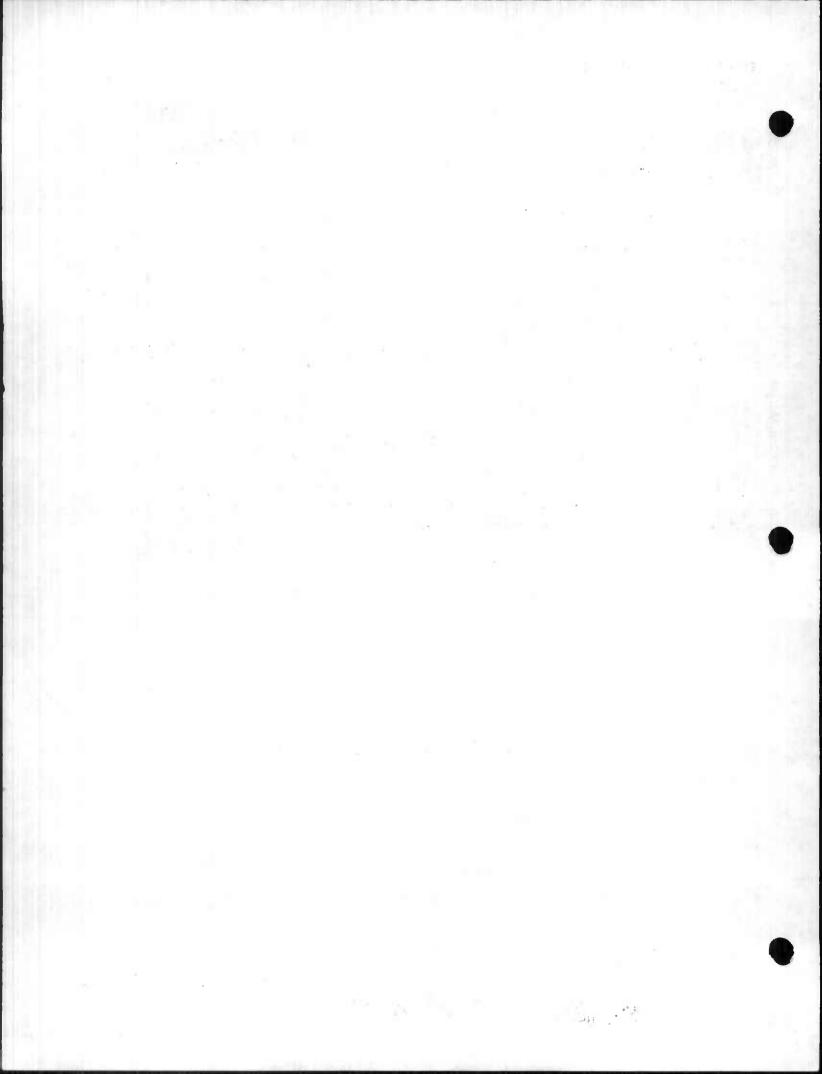
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15 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

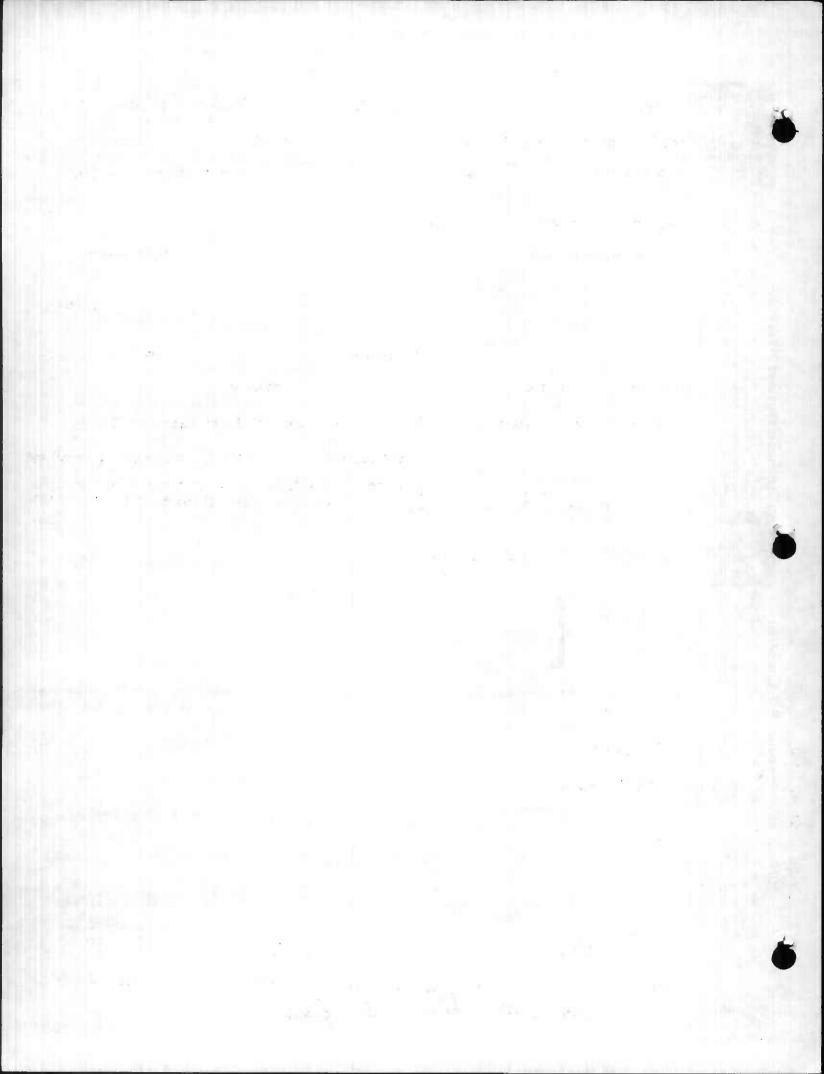
29b. Signature and title of certifian GIBRESM

30. Name and address of person who complated causa of daath (Itam 23a) (Type, Print) Hanover Street Baltimore MD 21225 3001 OS

State Registrar



	1. Decedent's Name (First, Middle, Las	st)		Certifica			2. Data of De			3. Time of Death	
an cal ner	MARIE  4a Facility Name (If not institution, giv.	A street and number)		Lau		4b. City, Town, or	Month Location of Deat	Day h 4c. County	of Death	2045	
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	17. Father's Name (First, Middle, Last) unknown Eas:				na ( <i>First, Middie</i> NOWN	, Maiden Suman	10)				
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	Richard H. Lowe J.										
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	Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			iew Cem			1-20-99	Svkesv	ille.	Maryland	
	23a. Part1. Enter the disease, or compshock, or heart failure. List only	one cause on each iir	ne.	4112 o not enter the n	old Co	itzke's lolumbia lolumbia log, such as cardia	Pike Ell	licott C			
	Immediate Cause (Final diseasa or condition resulting in death)	a. KRANYA	Dua to/(or as	a consequanca						Tons	
	Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Lasf	c		a consequence							
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	3 Suicide 6 Could not be datarmined	28e. Place of Injury - At home, farm, street, factory, obuilding, etc. (Specify)							ion (Street and Number or Rural Routa Number, or Town, State)		
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	- Julio		)		Plc Columbra, MD 21044						



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death 4:00 fm IlliAm An /Medical 4b, City, Town, or Location of Death 4c. County of Peath Examiner moRE OSPICE If Under 1 Yaa 8. Date of Birth (Month, Day, 9. Birthplace (Stata or Foreign Country)

N. CAROLI NA 7. Age (Ir yrs. last birthday) **Funeral** 10PM 2DF Days Yrs. Director 10c. Gity, Town pr Location 10d. Inside City Limits r than "natural", or home 23s or 28s-f show the Medical Examiner must be notified at 1 Xes 2 No Director IMORE 10e. Şt 10f. Zip Code 10g. Citizen of What Country? et and Number 22 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cyban, Mexican, Puerto Rican, atc.) Was Decedent Eyar in U,S. Armed Forces? Race - American Indian, Black, Whita, etc. 1 Yas 2 No If Yas, Giva Year or Datas: 1 Never Married 2 Married Specify: BlACK Maryland 21215-0020 1 Yas 2 No Specify 4 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Giva kind of work done during most of working)
Ifla. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 19h7 illed within 7 I Hyglene. condary (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filled w. Department of Health and Mental Hygien important: If them 27 is marked other than any injury or other transmission. 40 17. Father's Nama (Eirst, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) 8 RIE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) md 0 20b. Place of Disposition (Nama of cematary, crematory or other place) altimoré. 20a. Method of Disposition Data 20c. Expeation - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sal 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service-Light 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart tailure. List only one cause on ago. Approximate Interval Between Onset and Death **Physician** 20 HONTHS /Medical Immediata Cause (Final · SQUAMOUS CELL CARCINONA LUNG WITHETASIASES disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner the attending physician and thed for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown CARCINOMA PROSTATE Records. þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 280 No 1 ☐ Yas 2 ☐ No Vital 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 7 1 Inpatient 2 ER/Outpatient 3 DOA Division of this 27. Manner of Death 1 L Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred adical Certification: 28c. Injury at Work? 5 Pending investigation death. 1 Yes 2 No 2 ☐ Accident Director 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after A 4 Homicide To the Hoepital within 24 hours a To the Funeral C completaly filled 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

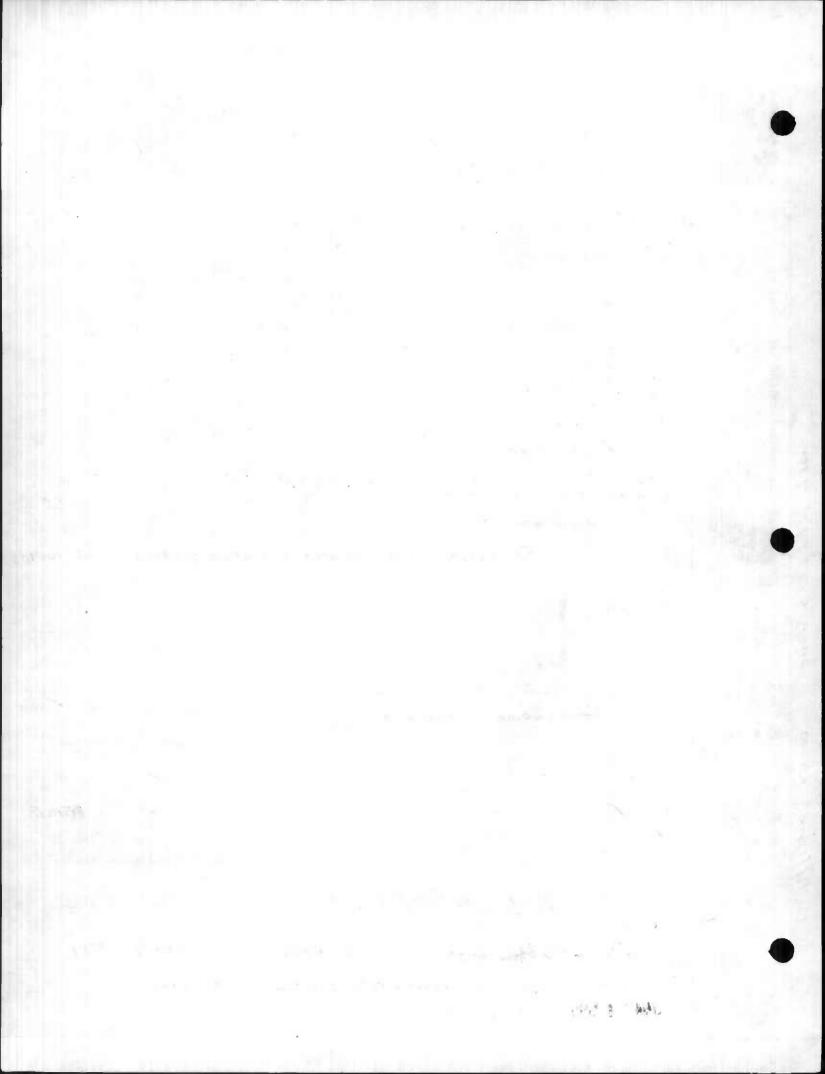
| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Junelyblow my JAN 18 ~ 1899 D06933 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar JOHN .B.

31. Date fled (Month, Day Year)

MACGIBBON MD 101 WREAD ST BALTIMORE MD

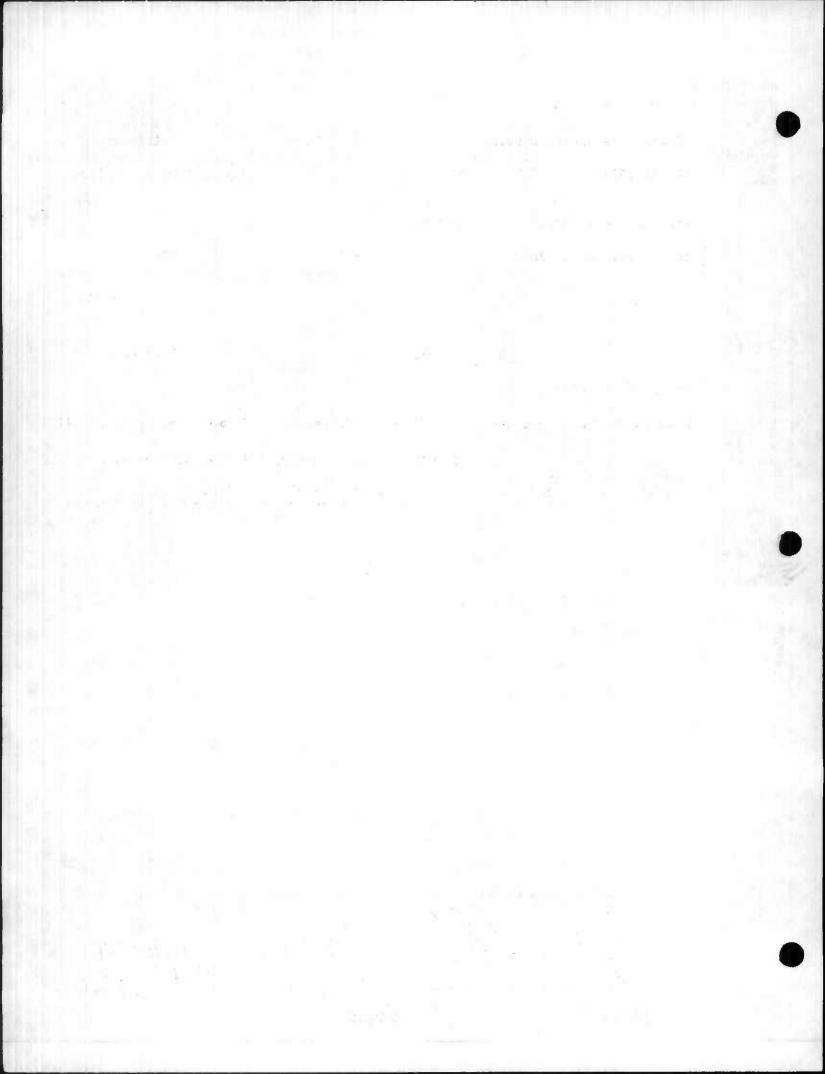
32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death Miller **Physician** Marie Month 40 3 /Medical 4a. Facility Nema (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Care Health Services Towson Baltimore If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, May 5, 9. Birthplaca (Stata or Foreign Country) Maryland 7. Aga (In yrs. last birthday) **Funeral** 1□ M 2 F Months Days Yrs Director 216-32-1697 92 Usual Rasidance of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 28a-f show 10d. toside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 or items 23a 16401 J.M. Pearce Road 21111 USA daath Funeral 12. Was Dacedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Ricen, atc.) 14. Race - American Indian, Black, Whita, atc. filed within 72 hours after 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: White by 3 □ Widowad 4 □ Divorcad Yeer or Dates: "naturel". Completed 15. Dacedent's Education 16a. Dacedant's Usuei Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry (Spacify only highast greda complated) Hygiena. Elamentery/Secondary (0-12) Coilege (1-4or 5+) 8 0 Homemaker Ownhome permit. Pagas 1 and 2 should be file Department of Haalth and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event ones. 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) Be George Crispens Jennie Feuer 19a. Informant's Name/Reletionship (Type, Print) 19b. Matting Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Frances Thomas / Daughter 16401 J. M. Pearce Road, Monkton, Maryland 21111 20b. Place of Disposition (Nema of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Buriat 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Degation 5 ☐ Other (Specify) New Cathederal Cemetery 1/18/99 Baltimore, Maryland 21 Si Funaral Service Licensee 22. Nama end Addrass of Fecility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Interval Between Onsat and Daath Physician /Medical Immediata Causa (Finet diseasa or condition rasulting in death) **Examiner** Physician/Medical Examiner bunal-transi Sequantially tist conditions, if any, laading to immediata cause. Entar Undarlying Cause (Disaasa or thjury that initiated avants rasulting in daath) Last The law requires that the death certificate be execu Box 68760. usa as the Dua to (or as a consequence of): Po P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, 2 page 2 should be 24b. Wara autopsy findings eveilabla prior to completion of cause of death? Completed 24a. Was an eutopsy performed? cartificate 1 Yes 1 Yas 2 No of Vital or Attending Physician: To Be 25. Was casa referred to medical 26. Piaca of Death (Check only ona) Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Menner of Death Aftart Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Division 5 Panding invastigation daath. 1 ☐ Yas To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident tha 6 Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicida 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of Examination and/or invastigation, in my opinion, death occurred at the time, date end piece, and due to the cause (s) and manner that the cause (s) and manner 29a. Cartifiar Medical (Check only one) impation and/or invastigation, in my opinion, daath occurred at tha tima, date end piece, and due to the ceuse(s) 29b. Signetura and title of certified 29d. Data signed (Month, Day, Year) 30. Name and ald (Item 23e) (Type, Print 0 31. Dala filed (Month, Day, Yaer, 32. Ragistrar's Signature State 1 9 1999 Registrar

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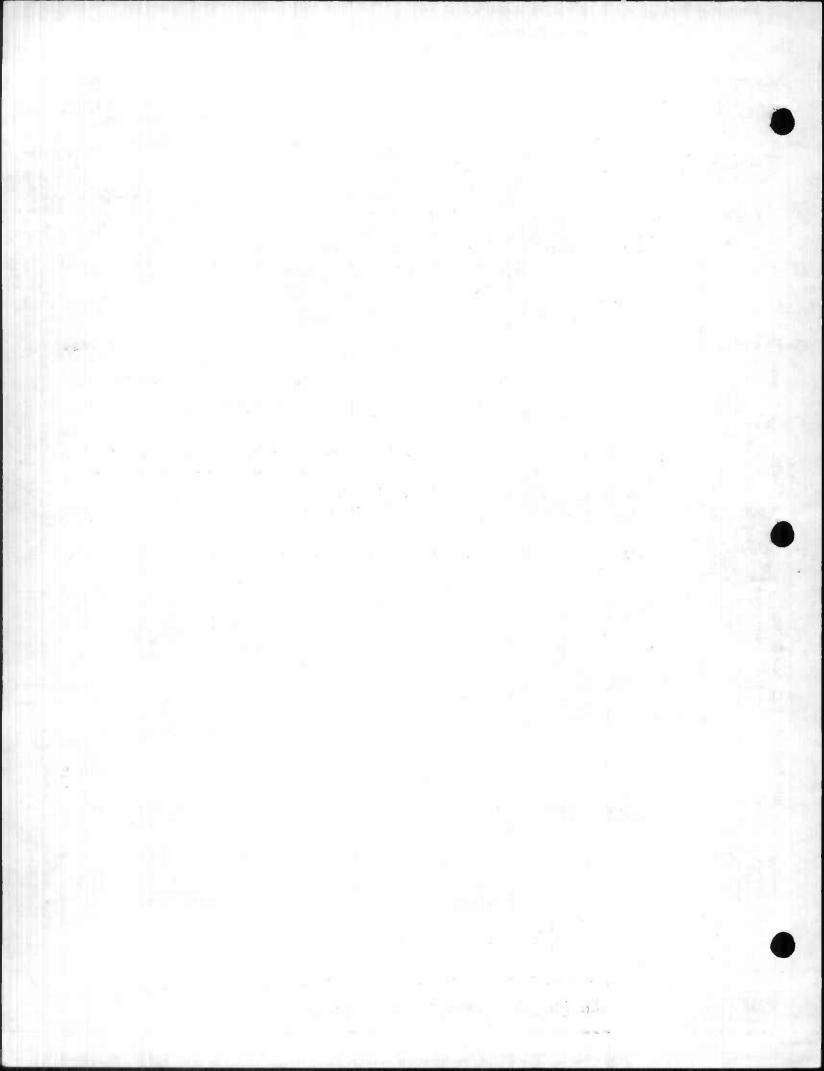


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Ray 6/95



Please Type or Print In Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vesi **Physician** JANUARY 16, 1999 Sr. Edward Regina McNamara O.S.F. 4:35 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 2以 F Yrs. Director 82 Oct. 4, 1916 219-58-5417 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or hams 23a or 28a-f show edical Exeminer must be notified at 1 Yes 2 No Director Md. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7620 York Rd 12. Wes Decedent Ever in U.S. Armed Forces? Funeral Joseph Convent 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Merried 1 Yes 2€ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry St. Joseph 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12 College (1-4or 5+) Pastoral Associate Medical Center altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 89 Department of Health and Mental reportant: If flem 27 is marked of Edward P. McNamara Flinn Regina 10 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Congregational Secretary Our Lady of Angels Convent Aston, Pa. 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donalion 5 ☐ Other (Specify) Most Holy Redeemer Cem. 1/20/99 Baltimore, Md. Ruck Towson Funeral Home, Inc. 21. Signature of Funerel Service Licenses 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** ISCHEMIC BOWEL /Medical Immediate Cause (Finel 13 DAYS disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enler Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as e consequence of): Box 68760. edical Due to (or as a consequence of): for use as Physician/M 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o the 3 1 Yes 2 No 3 Probably 4 Unknown م RENAL FAILURE signed t Records, by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed SPLENIC ARTERY ANEURYSM has 1 ☐ Yes 2 No 1 Yes certificate Division of Vital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 2☐ ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this After this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1. Neturel To the Hospital or Attending within 24 hours effect death.

To the Funeral Director: Affect completely filled in by the fune 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number 1-16-99 fOhn D-30263 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

Registrar

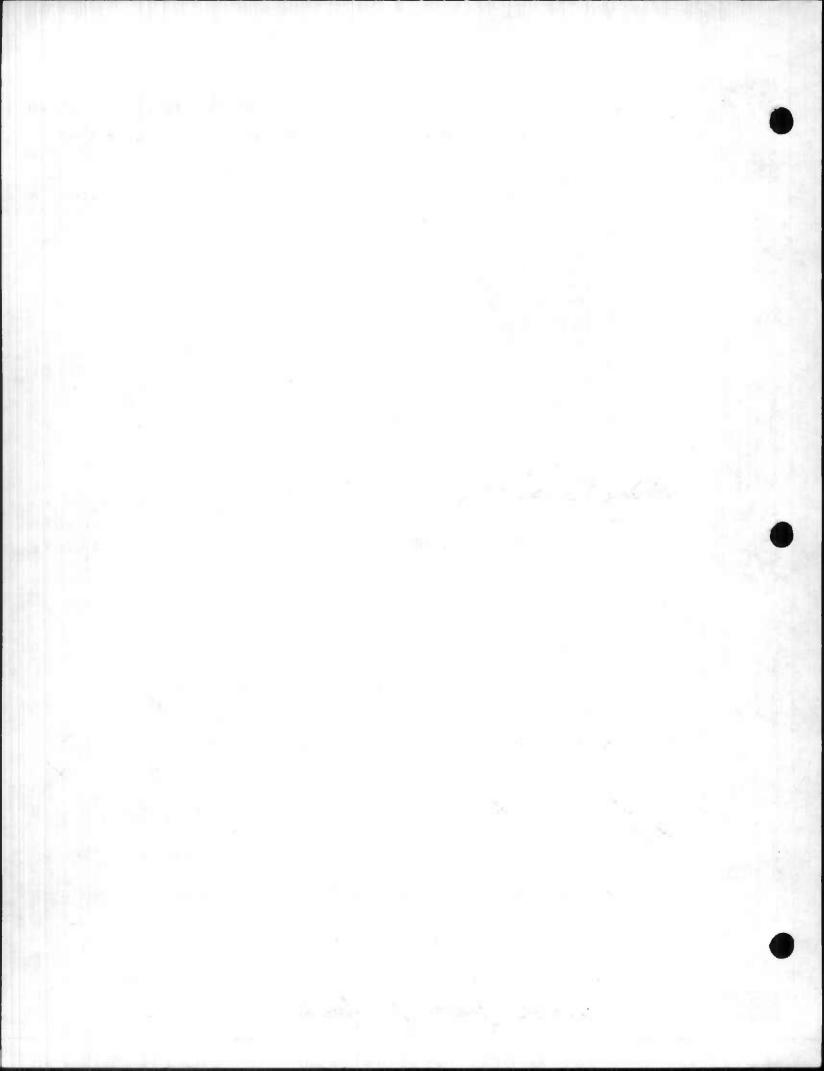
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31. Date lited (Month, Day, Year)

32. Registrar's Signeture

B. Sparks



State Registrar

DHMH 16 Rev 6/95

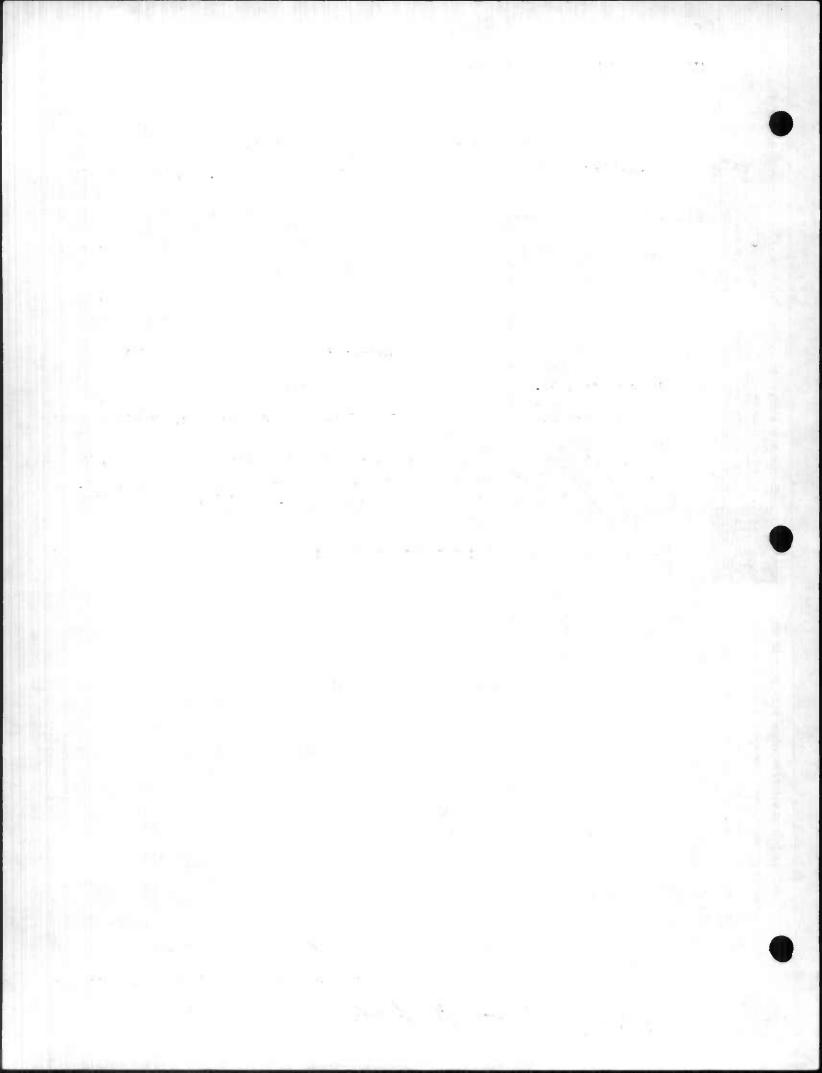
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Records,

Division of Vital

Examiner physician and the burial-transit

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To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical thet initieted events resulting in death) Last Due to (or es e consequence of)

Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Mellitus

23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 2 12 No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

Approximete Interval Between Onset and Death

3. Time of Death

ARUNDE

10d. Inside City Limits

1 Yes 2010

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 12 Inpatient 2 ER/Outpatient 3 DOA 28a. Dele of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

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32. Reo

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier

MD Name and address of person who completed cause of death (Item 23a) (Type, Print)

1999

31 Dan filed (Month, Dey, Year)

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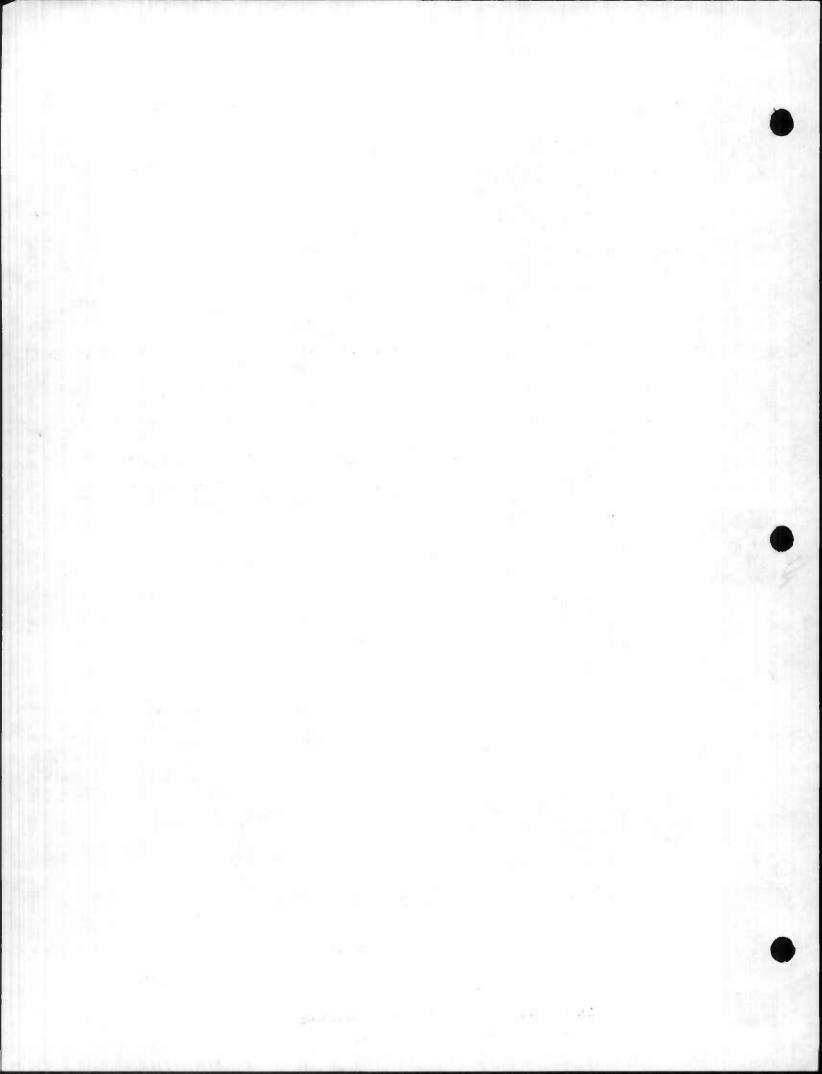
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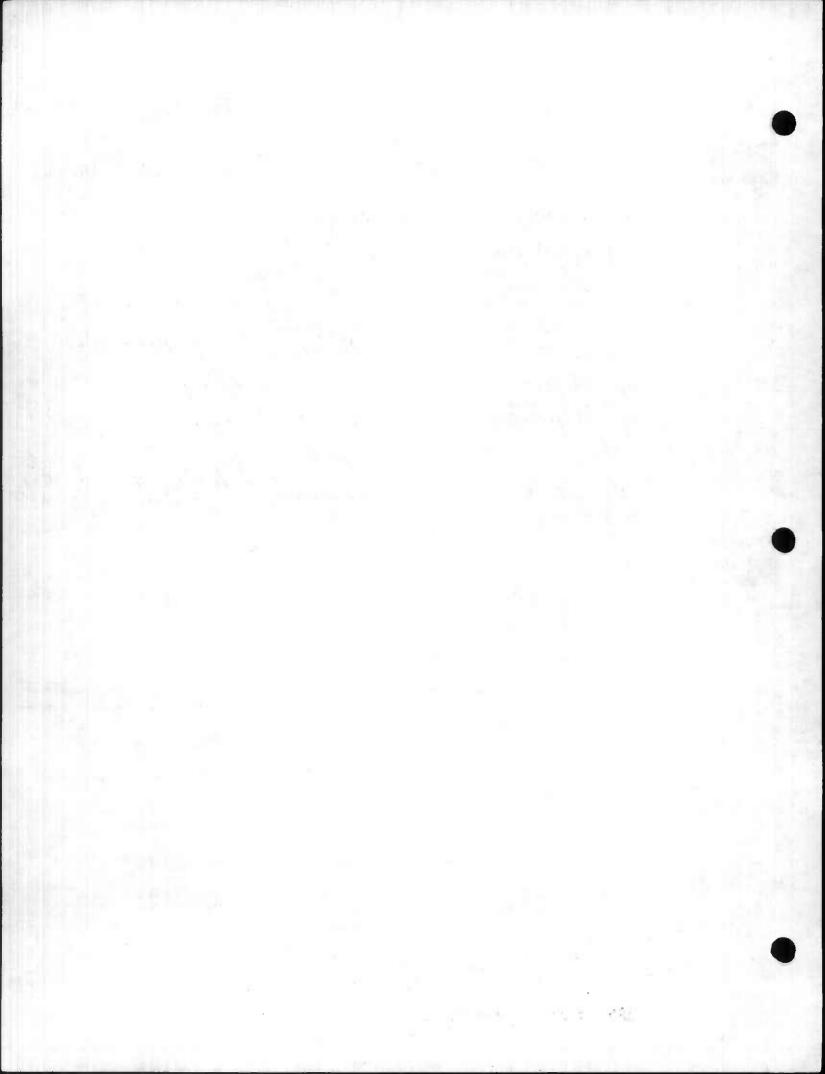
1 ☐ Yes 2 ☐ No



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	otato oi waryian	Certificate of Death	Reg. No.	00782
Physician	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Dey	3. Time of Death
/Medical	David Lee Moyer		Jan. 15, 190	99 8.45 a.M
Examiner	4a Facility Name (If not institution, give street and number)	Haspital West	or Location of Death 4c. County	of Deeth
	5. Social Security Number 6. Sex 7. Age (In yrs.		Irs. 8 Date of Birth	9. Birthplace (State or Foreign
Funeral Director	213 - 20 - 962   118 M 2□ F   C		Irs. 8. Date of Birth (Month, Day, Year)	Country Virginia
/anyland f ahow	10a. State 10b. County 10c. Cit	y, Town or Location SYKesville		10d. Inside offy Limits 1 3 Yes 2 No
of teme 23e or 23e-f show or teme 23e or 23e-f show or teme 23e or 23e-f show or teme 25e or 23e-f show or fearers! Director	10e. Street and Number 439 Kleenill Rd.	10f. Zip Code 21774	10g. Citizen of 1	What Country?
of the state of th	11. Marital Status 12. Wes Decedent Ever in U. Armed Forces?	,S. 13. Wes Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- 14. Rac	ce - American Indian,
by Pr. 478	1 Never Married 2 Memied  1 Never Married 2 Memied  1 Ves, Give Year or Detes:	If Yes, specify Cuben, Mexican, Pu	Specify	ck, White, etc. y: White
15-002 72 hours "neturel", alce Ex	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of a	working 16b. Kind of B	usiness/Industry
121215-0 ed within 72 ho regions. er than "natur t, the Medical.	Elementary/Secondary (0,12) College (1-4or 5+)	life. DO NOT use petired).  Michanic	Ant	bomobile
CA	17. Father's Name (First, Middle, Last)		Name (First, Middle, Maiden Suman	
ylanc buid be fi Mental H arked off afte aver	Toseph Moyer	Fla	e Miller	
Par and and and and and and and and and and	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Number, City or Town,	State, Zip Code) 21784
re, N 1 1 and 1 Health 1 Health 1 tam 27 other tr	20a. Method of Disposition 20b. P	Place of Disposition (Name of	Date 20c. Location	City or Town, Steta
man Pa ury	1 Burial 2 Differention 3 Linemoval from State	comotory, crematory or other place	1/19 Laure	1, Maryland
Balt. Departiment importulent interest	21. Signeture of Funeral Service Licensee	22. Name and Address of Facility K	evin A. Parker	Funeral Home
	23a. Pert1. Enter the disease, or complications that ceused the deat shock, or heart failure. List only one cause on each line.	n. Do not enter the mode of dying, such as cerd	diac or respiretory errest,	Approximate Interval Between
Physician / /Medical	Immediata Cause (Final	-00 0 -000	_	Onset and Death
Examiner	disease or condition resulting in death)	Ta Cardini Cerrist		3 min
2 2 2	CAD	i as a consequence ory.		15 m
8760, sate be associted thysician and the budal-transit dical Examiner	Sequentially list conditions,	r as a consequence of):		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Lachie		4400
- 10 2 4 8	resulting in death) Last	r as a consequence of):		
	a Dinles			1000
daath daath daath daath a short	Part II. Other significant conditions contributing to death but not resi	ulting in the underlying cause given in Pert I.	23b. Did tobacco use co	entribute to the cause of death?
Ids, P.O. Box quies that the death certified in signed by the attending build be deteched for use ed by Physician/M			1 No 2□ No	3 Probably 4 Unknown
Division of Vital Records, P.O. Box of varieties that the death center of the following Physician: The law requires that the death center of the following that the centificate has been signed by the attending in by the funeral director, page 2 should be detached for use entification: To Be Completed by Physician/Nertification: To Be Completed by Physician Physician Physi			24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause
Rec has law ga 2 a				of death?
	25. Was case referred to medical	OC Pleased	1 Yes 2 No	1 Yes 2 No
of Vita hysician his cariff il director	axaminer?	Other	Death (Check only one)  g Home 5☐ Residence 6 ☐ Oth	ner (Specify)
n of g Phy garthii neral	27. Manner of Death 1 2Natural 5 Pending (Month, Day Year)	28b. Time of lnjury at Work?	28d. Dascribe how injury occur	
SiOl andir or: At the fu	2 Accident investigation	M 1 Yes 2 No		
Division of the control of the contr	4   Homicide determined 28e. Place of Injury - At he building, etc. (Specif)	ome, farm, street, factory, office	28f. Location (Street and Numl City or Town, State)	ber or Rural Route Number,
Division of Vita To the Hospital or Attanding Physician: Within 24 hours after death To the Funeral Director: After this cardific completely filled in by the funeral director, Medical Certification: To Be (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knor one)  1 Medical Examiner: On the basis of axaminal and manner stated.	wledge, death occurred at the time, date and plation and/or investigation, in my opinion, death or	ace, and due to the cause(s) and moccurred at the time, date and place,	anner as stated. and due to the cause(s)
To the within comple	29b. Signature and title of cartiller	29c. License number	29d. Date signe	od (Month, Day, Year)
	> Thom mull	D2541	13 1/	15/99
Y	30. Name and address of person who completed cause of death (Item	23a) (Type, Print)	lestminter	n 1 7
	31. Darle liled (Month, Day, Year) 32. Megistrar's Signa	100	185mmla	MR X1117
State Registrar	31. Dafe liked (Month, Day, Year)  AN 1 9 1999  32. Registrar's Signa	G. Low Kal		

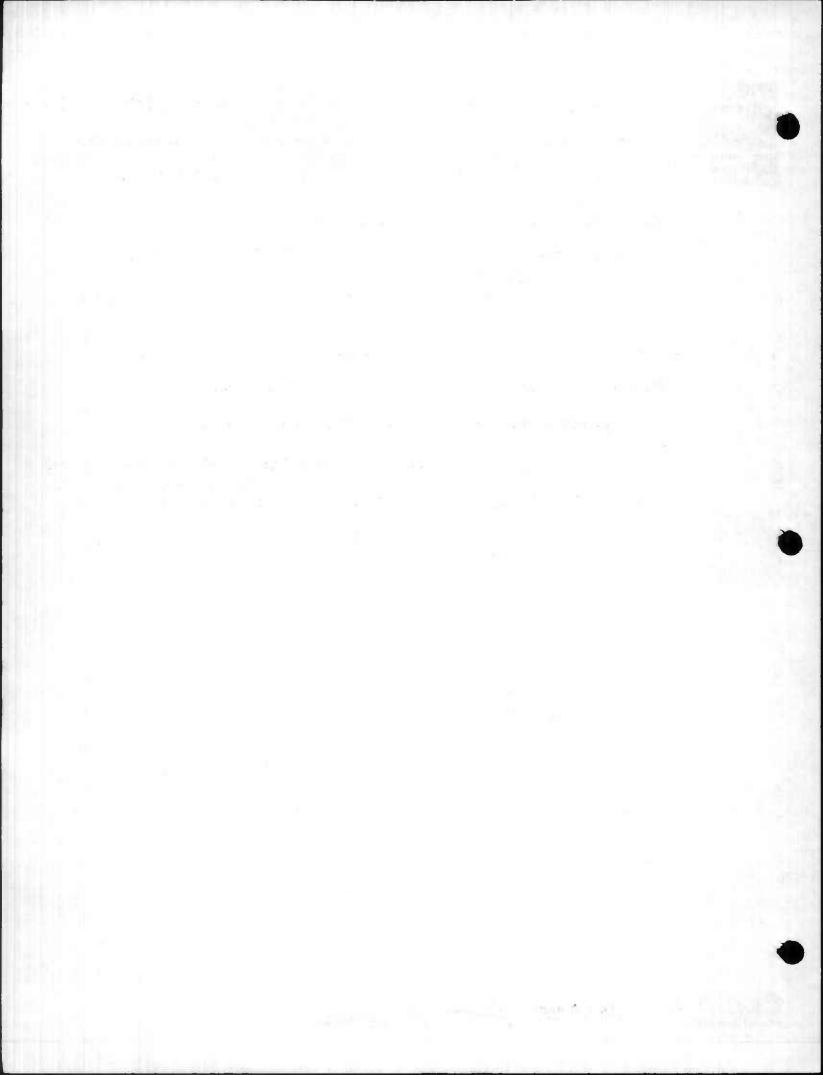
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3 Time of Death **Physician** January PB, 1999 12:15 a m Catherine Melnechuk /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Manor Care-Rossville Rosedale Baltimore Co. If Under 1 Yeer If Under 24 Hrs.
Months Days Hours Min. 8. Dete of Birth (Month, Dey, Year) March 7, 1907 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2**X**F Months 218-10-1455 91 Yrs. Director Austria Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 7 is marked other than "naturel", or itema 23a or 28a-f shov traumatic event, ore Medical Expiring roust be notified at 1 ☐ Yes 2 No Maryland Director Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7840 Daniels Avenue 21234 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ Specify: 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filled within nent of Health and Mental Hygiene. int: if itam 27 is marksd other than ' iry or other traumatic event, the Ms Elementary/Secondary (0-12) College (1-4or 5+) 4th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Theodore Bohonys Names Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Daniel Monch (nephew) 1201 Sterling Drive, Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Holy Trinity Orthodox Cem 1/19/99 Elkridge, Maryland 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signeture of Funeral Service Licensee a. Welley 9705 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Gram regative weeks Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Confestive Heart failure Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): and age IV sacral Records, P.O. Box 68760, Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Mashutrition 1 Yes 2 No 3 Probably 4 Unknown by Completed 24a. Was an autopsy performed? 24b. Were sutopsy findings avellable prior to completion of cause of death? this certificate has 1 ☐ Yes 2 ØNo 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? Certification: 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of After 5 Pending Investigation 1 Netural 1 ☐ Yes 2 ☐ No death. s after death 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled I 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Dey, Year) January \_16\_ (979 29b. Signature and title of cartifier 29c, License number 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Le Suite 203, Towson, MD 21204 MD 7600 FAHED 32. Registrar's Signature State Registrar



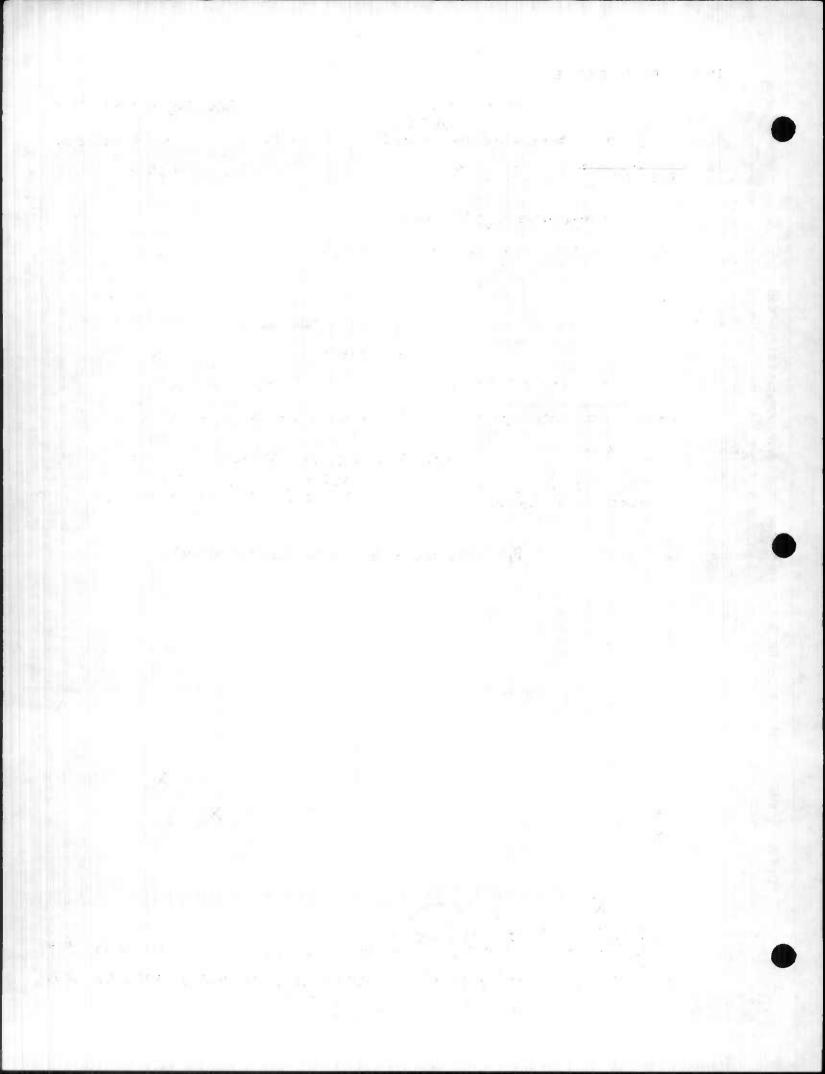
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#5 perFH G768 2/2/99 EW 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month 1615 **Physician** JANUARY 17, 1999 Dorothy Ann Mahar /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death APT DO05 Examiner EXCALIBUR DRIVE Bowie PRINCE GEORGES 6010 8. Dete of Birth (Month, Dey, Year) AUG 28, 19 If Undar 24 Hrs. If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months Days 10 M Q F Hours 219-21-2807 034-20-5276 Usual Residance of Deceder 69 1929 Director Massachusetts Deceden the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show 1 Yas 2 No Directo Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 16010 Excalibur Rd. Apt. D0005 20716 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Datas: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status Black, Whita, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes No Specify: Specify: White p 3K Widowed 4 Divorced Hygiene. other than "natural ent, the Medical Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Management Restaurant 7 is marked other traumatic event, 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be f nent of Health and Mental I nt: If item 27 is marked of Norman Angus Roberts Frances Bradshaw 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brenda L. Cressman/daughter 2616 Kresson Place Bowie, MD 20715 item 2. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata parmit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 01/19/99 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funerel Service yell The maid of Food Food of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 Gragorchik Edward A. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel WITH COMPLICATIONS DIABETES MELLITUS disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? is certificate has b director, page 2 s 1□Yes 2□No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27, Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ HomicIde To the Hospital or within 24 hours aft To the Funeral Di-completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examinar: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signethre and title of certifiar 29c. License number OME se of death (Item 28a) (Type, Print) MARIO F. MD V HOSPITAL PRIVE CHEVERLY GOLLE 3001 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

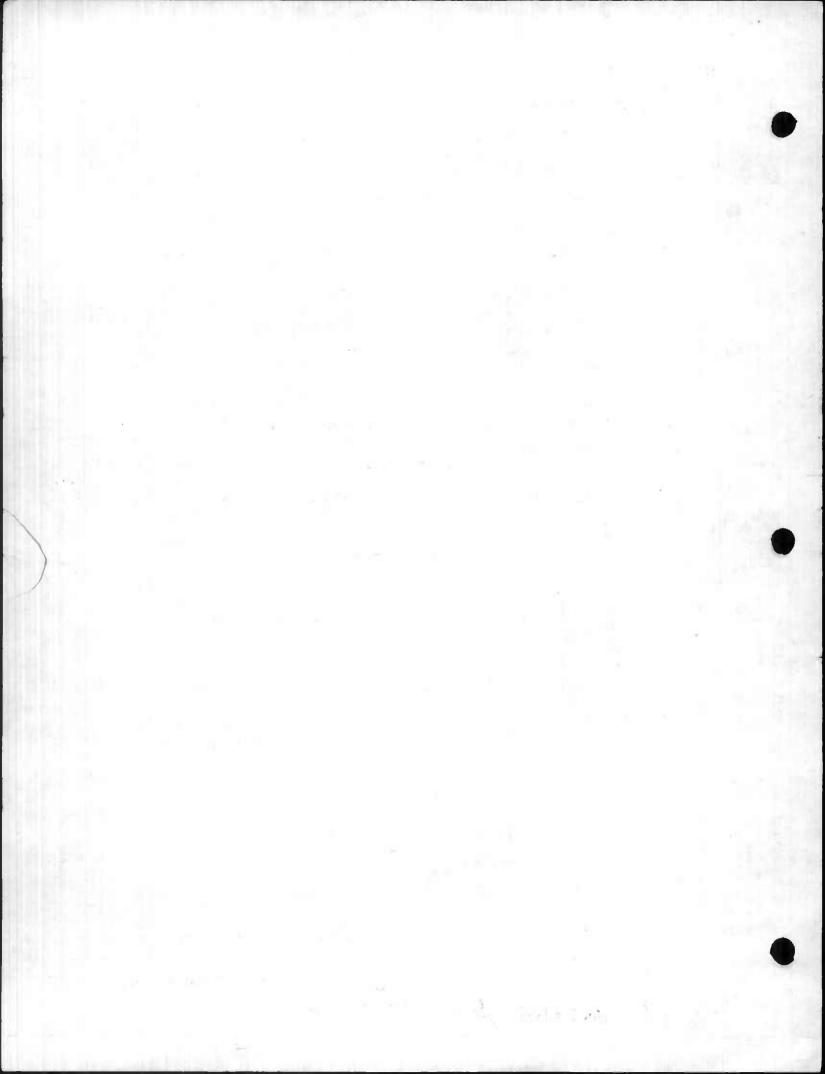
DHMH 16 Rav 6/95

State Registrar



State of Manyland / Department of Health and Mental Hydiene 0 0705

Physician	1. Decedent's Name (First,				2. Data of Do Month	Day	Year	Time of Death			
Medical	IRIS	McDOWE!		6-3			4h Cibi Tourn	JANUA	RY 1.3	3 1999 3. Time of 1999 4:01 County of Death N/A  9. Birthplace (State of Country)  10d. Inside Cingly)  10d. Inside Cingly et al. (State of Country)  4. Race - American Indian, Black, White, atc.  Specify: BLACK  d of Business/Industry  CTORY  Sumame)  70wn, State, Zip Code)  D 21205  Cation - City or Town, State  CIMORE, MD  RAL HOME, P.A.  DRE, MD 21217  Approximate Interval Bate of Conset and Interval Bate of Conset	4:01 A
kaminer	4a Facility Name (If not ins								N/A	Of Death	
neral ector	5. Social Security Number 219-86-6887		M 20 F	7. Age (In yrs. 37	last birthday) Yrs.			in. (Month, D.		9. Birthplace Country)	(State or Foreign
2	Usual Residence of Deced	County		10c. Ci	ty, Town or Lo	cation				Citizen of What Country?  SA  14. Race - American Indian Black, White, atc.  Specify: BLACK  Kind of Business/Industry  FACTORY  Iden Sumame)  by or Town, State, Zip Code)  MD 21205  Location - City or Town, State  ALTIMORE, MD  VERAL HOME, P.  LIMORE, MD 2121  Approximately	Inside City Limits
any injury or other traumetic avant, the Medical Examinar must be notified at page.  To Be Completed by Funeral Director	MD N	/A		BAI	TIMORE					1	Yes 2□No
	10e. Street and Number 2214 ROSLYN	ATTE				10f. Zip Code				What Country?	
	11. Marital Status  1 Never Married 20	1	Armed For	2☑No		Was Decedent of I f Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or Netro Rican, etc.)	0- 14. Rad Blad	ck, White, atc.	ndian,
	3 Widowed 4 Dir	becrov	If Yes, Give Year or Da	tes:					1		
publete	15. De (Specify only Elementary/Secondary ( -12-	cedent's Educ highest grade 0-12)	completed)  College (1-	4or 5+)	(Give	kind of work done OO NOT use retire	during most of v	working			y
O O	17. Father's Name (First, M	liddle, Last)			1	- 1	18. Mother's N	lame (First, Middle	e, Maiden Suman	ne)	
ToE	MARVIN McD										
	19a. Informant's Name/Re										de)
	MARVIN McD 20a. Method of Disposition	OWELL(	FAIHER	20b. I	Place of Dispo	sition (Name of		Date			State
	1 Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ Ot		emoval from S	tate				1_20_99	BALTIM	ORE MI	
	21. Signature of Funeral S		ch		22	. Name and Addr	ess of Facility	PHILLIPS	FUNERAL	HOME,	P.A.
al er	Immediate Cause (Final disease or condition resulting in death)			CARI	JIAC ARRI	4b. Chy, Town, or Location of Death   Ac. County of Death   BALTIMORE   N/A     st birthday   If Under 1 Year   HUnder 24 Hrs.   8. Date of Birth   N/A     st birthday   Yrs.   Months   Days   Hours   Min.   12 - 26 - 61   S. Birthplay   Yrs.   Months   Days   Hours   Min.   12 - 26 - 61   S. Birthplay   Yrs.   Months   Days   Hours   Min.   12 - 26 - 61   S. Birthplay   Yrs.   Months   Days   Hours   Min.   12 - 26 - 61   S. Birthplay   Yrs.   Months   Days   Hours   Min.   12 - 26 - 61   S. Birthplay   Yrs.   Months   Days   Min.   12 - 26 - 61   S. Birthplay   Yrs.   Months   Days   Min.   12 - 26 - 61   S. Birthplay   Min.   Months   Min.   Min.   Months   Min.   Min.   Months   Min.   Min.   Months   Min.		set and Death			
edical Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events	· { "								0 0 0 0 0	113
_	resulting in death) Last	d		00010 (0	as a conseq	uanua (ii).	H			1	
Physician/M	Part II. Other significant or	onditions cont	ributing to dea	ath but not res	sulting in the u	nderlying cause gi	ven in Part I.	23b. Dld	I tobacco use co	entribute to the	cause of death?
	CHRONIC ANEM	IA						10	Yea 2□ No	3 Probabl	y 49 Onknown
Completed by								24a. Wa	s an autopsy iormed?	availat	ole prior to etion of causa
mo								112	Yes 2□No	102 Ye	es 2 No
8	25. Was case referred to n examiner?	_	and to					Death (Check only	one)	Ame)  In, State, Zip Code)  21205  1 - City or Town, State  MORE, MD  L HOME, P.A  Approximatinterval Between and Interval Between and	
itlon: To		Pending investigation		patient 2 C f tnjury n, Dey Year)	28b. Time of Injury	28c. Inju	ry at ork?				
Certification:	3 ☐ Suicide 6 ☐ 6	Could not be determined	28e. Place o	of Injury · At h g, etc. (Speci	ome, farm, str fy)	set, factory, office				ber or Rural Ro	oute Number,
Medical Certification: 1				sis of examina							
M	29b. Signature and title of o	is .	Christ	3 no		Ab. City, Town, or Location of BALTTIMORE    Hunder 1 Year   Hunder 24 Hrs.   8. Dat   Months   Days   Hours   Min.   12 - 12 - 12		_			
	30. Name and address of p	manufaka	npleted cause		- 00-1 CT	D 1 45				13 1999 4 County of Death N/A  9. Birthplace (School) 10d. Ins 18  11d. Race - American Indi Black, White, atc.  Specify: BLACK (Ind of Business/Industry) ACTORY 10d. Sumame)  10d. Ins 18  11d. Race - American Indi Black, White, atc.  Specify: BLACK (Ind of Business/Industry)  ACTORY 10d. Sumame)  10d. Ins 18  10d.	



30. Name and address of person

HEIAN

State Registrar CARROLL

completed cause of death (Item 23a) (Type, Print)

7600

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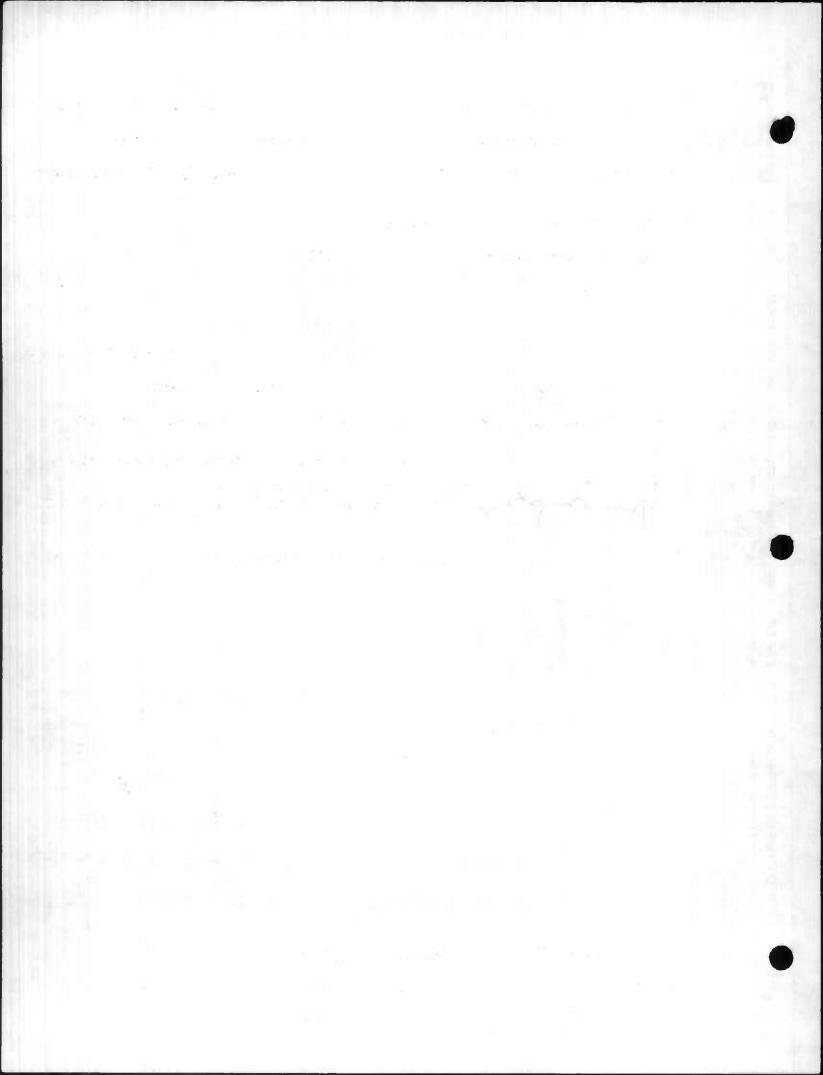
INYEL

1 9 1999

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 3. Time of Death 1 Decedent's Nama (First Middle Last) **Physician** January 13, 1999 Matysek 12:46 PM Mary Ann /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Nama (If not institution, giva street and number) Examiner "C" North Avenue 1002 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Aug. 12, 1 Essex Baltimore 5. Social Sacurity Number 7. Aga (In yrs. lest birthday) 9. Birthplace (Stata or Foraign **Funeral** Months 10 M 20 F Yrs. 1934 Pennsylvania 64 205 26 8225 Director Usuel Rasidence of Dacedant with the Marylend 10a. Stata 10b. Count 10c. City, Town or Location 10d. Insida City Limits "naturel", or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "C" North Avenue 1002 21221 USA death \ Funeral 14. Race - Amarican Indian, Bleck, White, atc. 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status should be filed within 72 hours after and Mental Hygiena. 1 Yes 2 No
If Yes, Giva
Yeer or Datas: 1 ☐ Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: p 3 Widowed 4 Divorced White Completed treumstic event, the Medical 15. Decedant's Education (Specify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b Kind of Rusiness/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) Maryland State Gov. 12 Clerk / Typist and Mental Hygie Is marked other t 18. Mothar's Name (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middia, Last) Thomas Buczek Katherine Malik 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) permit. Pages 1 end 2 s
Department of Health an
Important: if item 27 is any injury or other treus 9 1002 "C" North Avenue Essex, Maryland 21221 George Matysek Sr. (husband) 20b. Place of Disposition (Nama of cematary, crametory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 15 Buriel 2 Crametion 3 Removel from State 4 Donation 5 Other (Specify) Sacred Heart of Jesus 1/15/1999 Baltimore County, Md 22. Name end Addrass of Facility Bruzdzinski Funeral Home PA 1407 Old eAstern Avenue Essex, Maryland 21221 Har the disaasa, or compications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in daath) 26 MON741 Examiner Examiner physician and the bunal-transit The law requires that the death certificata be executed Sequantially list conditions, if any, laading to immadiata cause. Enter Undarfying Cause (Disaese or injury that initiated avents rasuiting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or es e consaquance of) SB 23b. Did tobacco usa contributa to the cause of death? ed by the a Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed peed completion of causa of death? hes page 2 1 ☐ Yes 2 🕅 No 1 ☐ Yes 2 ☐ No certificata or Attending Physicien: director, 25. Was case referred to medical axaminar? Be 26. Place of Death (Chack only one) Hospital: Other: 4□ Nursing Homa 5 🔀 Rasidance 6 □ Othar (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funaral 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 28a. Date of Injury (Month, Day Yaar) Certification: After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accidant invastigation Director: A 6 Could not be datarmined 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 24 hours eft Funeral Di letely filled in 29a. Cartifiar 1🕱 Certifying Physician: To tha best of my knowledge, daath occurred at tha tima, data and place, end dua to tha causa(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death utem 23a) (Type, Print) PURRU MALTINOR JHBUML 4940 EASTERM MILHARC 32. Registrar's Signature State Registra **DHMH 16 Rev 6/95** 



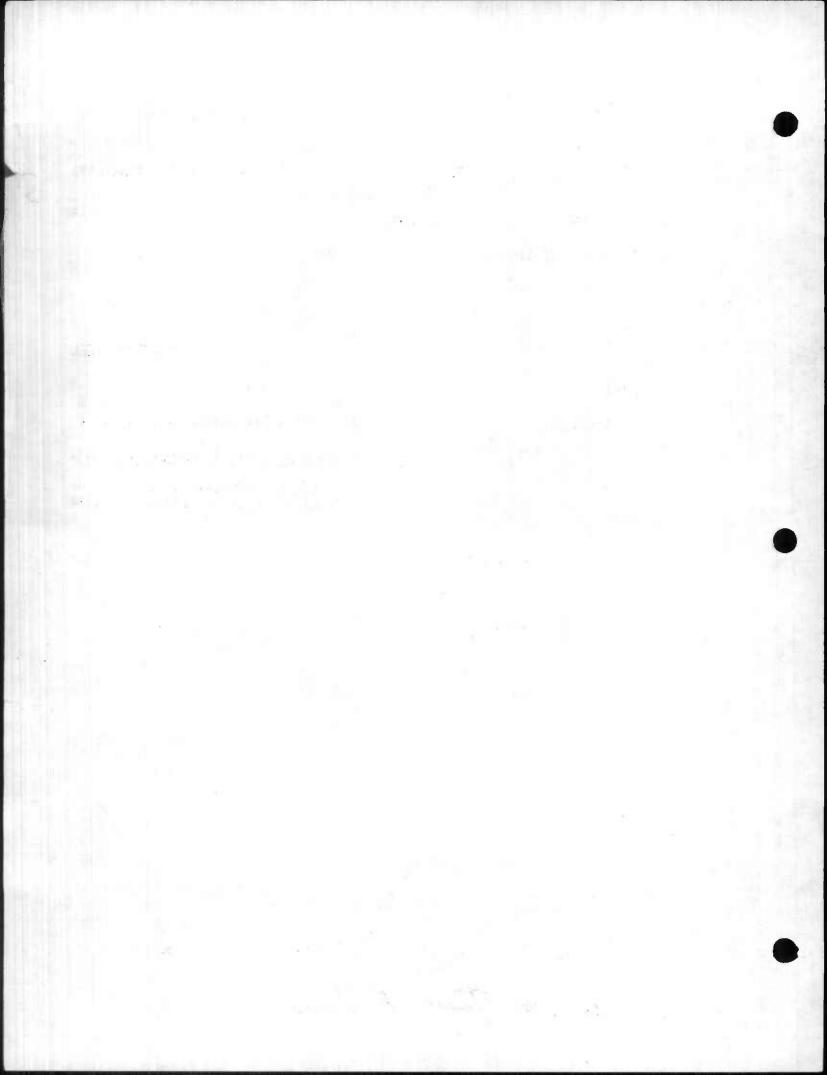
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					Certifi	cate of	Death		Reg. No.	9 0	0100	
ysician	1. Decedent's Name (Fin				2. Date of Do	Date of Death     Month     Day     Year     3. Time of D						
cian Iical	JAMES R	. MORG	AN	Linnin				JANUAL		199	9 5:05 PM	
iner	4a Facility Name (# not	institution, give	street and number)				4b. City, Town, o	r Location of Deat		unty of Dea	th	
ı	FRANKlin	SQUAR	E Hosp	iTA1	Centi	ek	Rose		B.	41Til	MORE	
Ī	5. Social Security Number	Ar.	x 7. Ág XM 2□ F	11/2/2010	Mo	Inder 1 Year	Hours Mi	s. 8. Date of Bi (Month, Di	rth ay, Year)	9. Bir	thplace (State or Foreign ountry) Y LAND	
-	215-18-7015			76	Yrs.			Sept.	3,1922	MAR	YLAND	
-	Usual Residence of Dec 10a, Stete 10b	edent . County		10c. City.	Town or Locatio	n					10d. Inside City Limits	
I		-16									¥XYes 2□No	
ŀ	MD .	N/A		BAL	TIMORE	Vf. Zip Code		I	10a Citizar	of What Co		
1		TOMOUNT	AVENUE			212	2.4		U.S.		Juliuy :	
ŀ	3511 E. FA	IRMOUNT	AVENUE 12. Was Decedent	Ever in II S	13 Was			Specify Yes or N			erican Indian,	
	1 Never Married	XYMarried	Armed Forces?  1XX es 2 1  1 Yes, Give	No			an, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)		Black, Whit		
	3 Widowed 4		If Yes, Give Year or Dates:	9//-/	16 101	es 2XXNo	Specify:		Sp	ecify:	IITE	
	15.	Decedent's Edu		. 544 -	16a. Decedent's	Usuat Occup	pation		16b. Kind	of Business		
ŀ		nly highest grad			(Give kind life. DO N	of work done OT use retire	during most of w	orking				
	Elementery/Secondary	y (0-12)	College (1-4or 5	LABORER	_ABORER			BETHI	EHEM	HEM STEEL		
ĺ	17. Father's Name (First	, Middle, Last)					18. Mother's N	ame (First, Middle	e, Maiden Su	mame)	ne)	
١	UNKNOWN		UNK					IOWN				
Ì	19a. Informant's Name/I	Relationship (T)	rpe, Print)		19b. Mailing Ad	dress (Street		Rural Route Numb	ber, City or T	own, State,	Zip Code)	
ı	PATRICIA MO	RGAN/WI	FE		3511 E.	FAIRM	OUNT AVE	NUE, BALT	IMORE.	MD. 2	21224	
Ì	20e. Method of Dispositi	on		20b. Pla	ace of Disposition	(Name of		Date	T		Town, State	
l	1)(A)(Burial 2 Cre 4 Donation 5 D		Removal from State			ANS CEM.	1/19	CROWN:	SVILLE	МО		
ŀ	21. Signature of Funeral		99	CKOV	22. Na	ne and Addre	ess of Facility				-,110	
	1	-	-167					. FUNERA			01001	
+	23a. Part1. Enter the dis shock, or heart feil	sease, or compl	ications that caused	the death.		S. CON	KLING_S]	REET, BAL	_T_MUK] arrest.	E.MU.	21224 Approximate	
	shock, or heart feil	ure, List only or	ne cause on eech li	10.							Interval Between Onset and Death	
Immediate Cause (Finat												
1	disease or condition resulting in deeth)		sepsi.	S Dua to (or		no of):					1 Mon TH	
1			Sepsi.	10) 01 600	as a consequent	e orj.					1	
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If any, leeding to immediate cause. Extra linderthing								-	1			
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ŀ	Part II. Other significant	conditions cor	ntributing to death b	ut not resul	ting in the under	ying cause gi	ven in Part I.	23b. Did	I tobacco us	e contribut	a to the cause of death?	
								10	Yas 2k	No 3□F	Probably 4 Unknow	
						-		-	/-			
									s an autopsy lormed?	24b.	Were autopsy findings available prior to	
											completion of cause of death?	
								10	Yes 20	No	1 ☐ Yes 2 ☐ No	
	25. Was case referred to	medical					26. Piace of D	eath (Check only	one)			
1	examiner?	F	lospitel:	nt 2 E	R/Outpatient 3	DOA Ot	her: 4 Nursing	Home 5□Res	sidence 6	Other (Spe	ecify)	
-	27. Manner of Death		28a. Date of Inju (Month, Da		28b. Time of	28c. Inju	ry at	28d. Describe	how injury o	ccurred		
	i SUNaturet 5[	Pending investigation	(MOHIII, Da	y reary	tnjury N		Yes 2□No					
3 Suicide 6 Could not b		Could not be determined						28f. Location (Street and Number or Rural Route Number				
	4   Homedo		building, et		City or Town, Stete)							
-	29e. Certifier 156	Certifying Phys	nician: To the best oner: On the basis of	of my know	ledge, death occ	urred et the ti	ima, date and pla	ce, and due to the	cause(s) ar	nd menner a	is stated.	
	one)	Medical Exami	and manner sta		on and/or investig	ation, in my	opinion, deeth oc	curred et the time	, date end pi	ace, and du	e to the cause(s)	
	29b. Signature and title	of certifier				29c. Licen			29d. Date s	signed (Mon	th, Day, Year)	
1	1/	11		ms	D	DS	3462		1/12/	99		
ŀ	30. Name and address of	f person who co	ompleted cause of d	eath (Item	23a) (Type, Print			100	1.1			
	Do. Jude. 1	Munes	9000	Fn.	ullin S	au and	= No. R	AITIMA	E M	ANNI	1412122	
ď	31. Date filed (Month, De		32. Regist	r's Signatu	No.		1		1	a y		
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State Registrar

MORGAN

JAMes



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jan 16, 1999 1:54pm Mildred E. Merryman /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carroll Co. Westminster Carroll Co General Hospital H Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1□M 2♥F 87 214-03-7716 Director Mar 12, 1911 Maryland Usuei Residence of Decedent 10a State 10b. County 10c. City, Town or Location mast be notified at 10d. Inside City Limits 1 XYes 2 ☐ No Reisterstown Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A Items 23s 21136 Funeral 4808 Piney Grove Road death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 72 hours after 1 Yes 27 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 21215-0020 natural', or Specify: White 1 Yes 2 No Specify: 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic avent, fine Media page. Elementary/Secondary (0-12) Coilege (1-4or 5+) Domestic/Cleaning Self-employed unk Baltimore, Maryland 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William S. O'Neil Elsie Weaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4808 Piney Grove Road, Reisterstown, Md 21136 Gwendolyn Hawkins (Daughter) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Murial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 1/19/99 Baltimore, Maryland 22. Name and Address of Facility
A. Alan Seitz, Jr. Funeral Home 21. Signeture of Funeral Service Licensee Man 3818 Roland Avenue, Baltimore, Maryland 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate intervel Between Onset and Deeth **Physician** /Medical immediate Cause (Final menutes disease or condition resulting in death) Examiner Examiner physician and the burial-transit the deeth certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of): 950 Part ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t Mullatur 1 Yes 2 No 3 Probably 4 Unknown A 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yes 2 No 1 Yea 2 No Division of Vital Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day Year) 28c. injury at Work? After 1 Naturai 2 Accident 5 Pending death. 1 Yes 2 No investigation n 24 hours after death be Funeral Director: A pletely filled in by the f 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide ò 29a. Certifier edicai Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Fune (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner ateted. within 2 To the \$ 29b. Signature and title of certifier 29c. License number 29d. Date aigned (Month, Day, Year) Dhewart Walen MA 126394 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BBUTO MI) 21210 WEGGERM 220 W. COLD SPRING LA DUNBUD T

DHMH 16 Rev 6/95

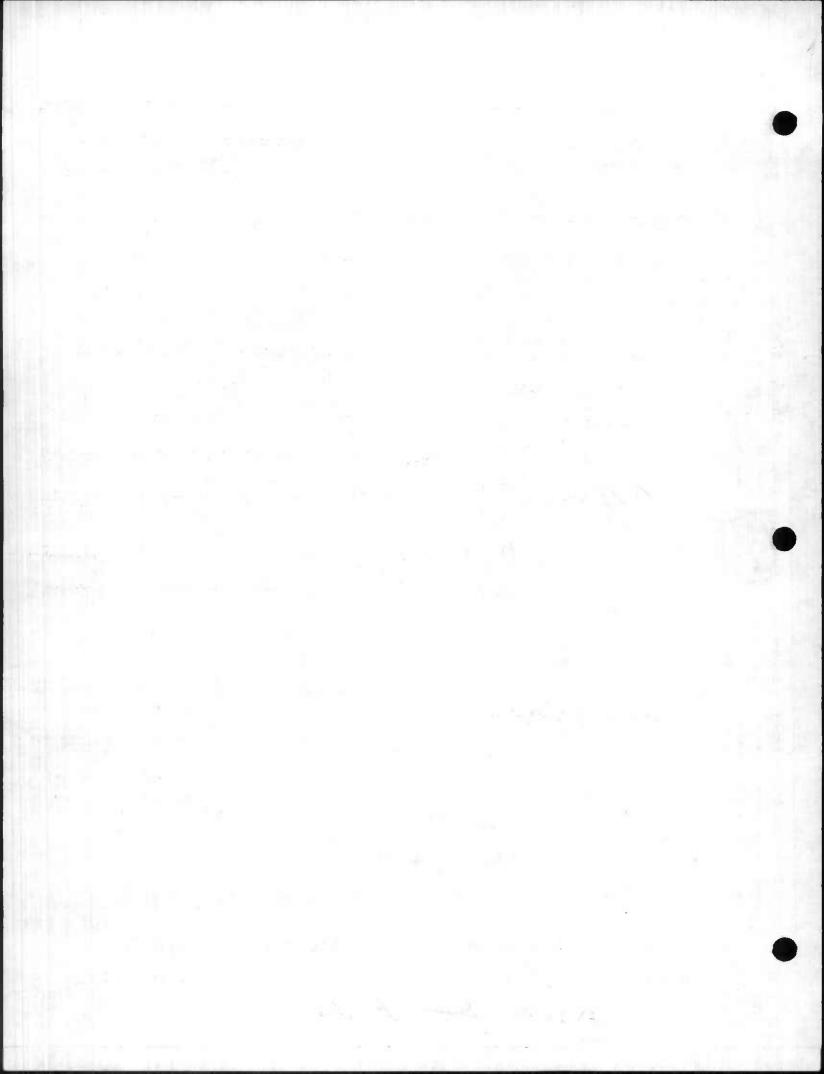
State

Registrar

31. Dete filed (Month, Dey, Year)

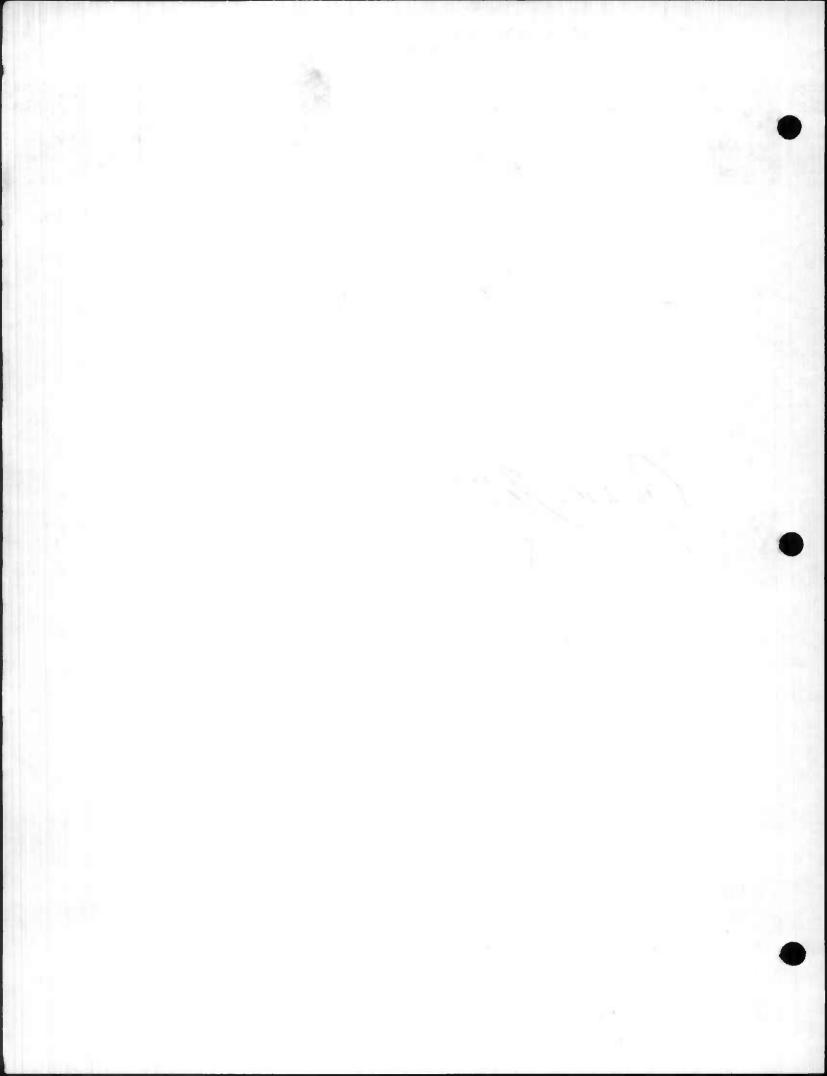
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32. Registraris Signature



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		Decedent's Neme (First, Middle, Last)	(1	Certificate of	Death	Reg 2. Date of Deeth	. No.	3. Time of	Death
Physicia /Medic		I the Maxw			3	Month	0	ger // 2	20a,
Examin	er	4a. Facility Name (If not institution, give street and num	ber)		4b. City, Town, or Lo	cation of Death	4c. County of	RROL1	1
Funeral Director		r	7. Age (In yrs. last bi 75	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y July 23,	923	Birthplace (State of Country) Georgia	v Foreig
f show led at	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Howard	10c. City, Tov		Columbia			10d. inside Cit	
ms 23a or 28a-f show crist be notified at	il Director	10e. Street and Number 6364 Barefoot Boy		10f. Zip Code	21045	10g	. Citizen of Who		
"natural", or lisms 2 ledical Examiner mu	by Funeral	11. Marital Stetus  1 Nevar Married 2 Married  1 Nevar Married 2 Married  3 Was Decernate For 1 Yes, Give 3 H Yes, Give Yeer or Da	No	13. Wes Decedent of H if Yas, specify Cube 1 □ Yes 2 No	lispenic Orlgin? (Spe an, Mexican, Puerto Specify:	ocify Yes or No- Rican, atc.)		American Indien, White, etc. Black	
than the	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12)  College (1-	16e	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Telepho	nation during most of working dipone Operator	ng 16	b. Kind of Busin	ness/Industry elephone	
d Mental Hygi marked other matic event, 1	To Be C	17. Father'a Nama (First, Middle, Last) Charlie Lee Shivers			18. Mother's Name		iden Sumeme) 1 Mitchell		
9 16 6		19a. informant's Name/Relationship (Type, Print) Mrs. Gerry Maxwell-Jones	Daughter 191	b. Meiling Address <i>(Street</i> 6364 Barefoot	and Number or Rura Boy Columbia	il Route Number. Ca., Maryland 2	ity or Town, St. 1045	ate, Zip Code)	
artment of Health ortant: If them 27 injury or other to 8.		20a. Method of Disposition  1 Burial 2 Cramation 3 Removal from S  4 Denation 5 Other (Specify)	20b. Place of comete Ar	of Disposition (Name of ary, cremetory or other plea butus Memorial Pa	ark, Inc.	Dete 20 01/15/99		ty or Town, State ore, Maryland	
Depart Import any inj once		Ineture of Funeral Service Licensee	M00535 -	22. Name and Addre 3871 O	นิกิยาลักไฟome, ld Columbia P	P.A. Pike Ellicott C	ity, MD 21	043	
nysician Medical kaminer	niner	mmediate Ceuse (Final disease or condition resulting in death)	sheim	en la D. consequence of):	ementi	α.		Approximate interval Betwoenset end E	Daath
attending physician end I for use es the burial-transit	in/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest		consequence of):					
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± 62		27. Manner of Death 28e. Date of	Injury 28b.	Time of 28c. injury Wor		28d. Describe how	_		
within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined 28a. Placa of building	f injury - At homa, fo g, etc. (Specify)	arm, street, factory, offica	2	28f. Location (Stree City or Town, S	et end Number Stete)	or Rural Route Numi	ber,
24 hou Funer letely fil	edical	29a. Certifler (Check only one)  1 Certifying Physician: To the base and manner on the base on the part of the base of the part of the base of the part of the par	is of examination er	e, death occurred at the tin nd/or invastigation, in my o	ne, date and plece, e pinl <i>on</i> , death occurre	end due to the caused et the time, date	se(s) end mann and pieca, and	er as stated. d due to the cause(s)	)
To the	-	29b. Signature and title of certifier	Inght	29c. Licans	a number 5 2 74	40 29d	. Data signed (	Month, Dey, Year)	w.
10		30 Name and address of person who completed cause	of deeth (item 23a)	(Type, Print)	oad s	skesvill	le M	D 2178	34
1 0		- INCOME OUT AT	110,01	BA CCLIL IS				- 41/(	1 ]



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4b. City, Town, or Location of Death William Ray Nitterright, Sr. 4c. County of Death 4a Facility Neme (If not institution, give street end number Glen Burnie A ar | ff Under 24 Hrs. | 8. Date of Birth ys | Hours | Min. | (Month, Dey, Year) North Arundel Hospital Anne Arundel If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 1**X** M 2□ F Deys Yrs. 178-12-6420 Sept. 5, 1922 | Pennsylvania 76 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 26 North Jerome Parkway U.S.A. 21060 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Sacondary (0-12) College (1-4or 5+) 12th Boilermakers Local 193 Construction 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) Rebecca John Nitterright Mathias 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) Mary Lenore Nitterright (Wife) 26 North Jerome Parkway Glen Burnie, Md. 21060 Plece of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Meadowridge Memorial Park1/21/99 Elkridge, Maryland 22. Name end Address of Fecility McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licensee 237 E. Patapsco Avenue Baltimore, Maryland 21225 or heart failure. List only one ceuse on each line. Approximeta Interval Between Onset and Deeth Immediate Cause (Final diseese or condition rasulting in daath) Sequentially list conditions, if any, leeding to immediate ceusa. Entar Undarlying Cause (Disaasa or Injury thet initieted events rasulting in deeth) Lest 23b. Did tobacco use contributa to the causa of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No Dise an 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 Yes 2 10 check only one)

physician and the burial-transit 88 980 Division of Vital Records, P.O. signed by I has death. after death 8

**Physician** 

/Medical

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Director

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Completed

**Funeral** 

Director

tem 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avant, the Medical Exeminer must be notified at

al Hygiena.

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permit. Pages 1 and 2: Department of Health at Important: If Item 27 is any Injury or other traugonce.

**Physician** /Medical

Examiner

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William

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

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	Wes cese examiner?  1 Yes		
7.	Menner of	Deeth	

1 Denpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how Injury occurred 28c. Injury at Work?

1 Neturel 2 Accident 3 ☐ Suicide

4 Homicida

5 Pending Invastigation 6 Could not be datamined

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifian (Check only one)

1 🗗 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and mannar as stated. 2 Medicat Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

29c. License number

29d. Dete signed (Month, Day, Year)

30. Name and address of person who complated cause of death (Itam 23e) (Type, Print)

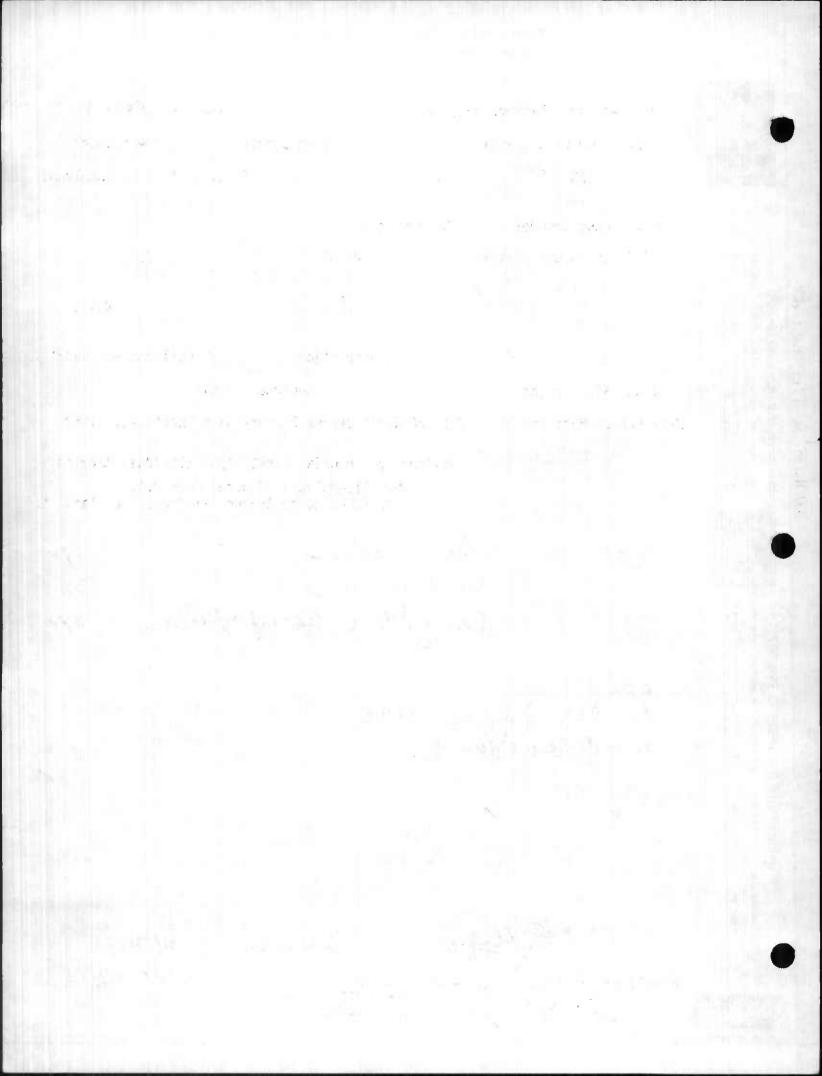
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Registrar

31. Dete filed (Month, Dey, Year) JAN 191999

Funeral

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#### Please Type or Print in Biack Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 16 1999 **Physician** Hester 10:40AM Nea /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 5. Social Security Number If Under 24 Hrs. If Under 1 Yeer 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 M 2 F 216-28-692 Yrs Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location ma 23a or 28a-f ahow 10d. Inside City Limits 1 Yes 2 No Director An more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death with Department of Heelth and Mental Hygiene. Introductant: If Hem 27 is marked other than "naturals, or thema 28a or any Injury or other traumatic avent. er Trenco Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No if Yes, Give Yeer or Detes: 4. Race Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 11. Merital Status American Indian Bleck, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 20 No Specify: þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 14RSINS MIDE 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) EdWARD okence 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rugal Route Nup ther, City or Town, State, Zip Code) Anie 25 TIMORE 20b Plece of Disposition (Name of communy, crematory or priner p 20e. Method of Disposition 20c. Location - City of Town, Stete 1 DBuriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 70 21. Signet of Funeral Service Dicensee Home UNERA 401 Edmondson DALTON Hve 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heert failure. List only one cause direct line. Approximete vel Betw Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Pulmonory Four years Examiner Due to (or as a consequence of): Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) USB : Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy 1 Yes 2 No 1 ☐ Yes 2 1 No certificate To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No edicai Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 MNetural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d, Date signed (Month, Day, Year) m.D. RES-000 January Sixteenth, 1999 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Kraig Kinchen. 110 Tower, Johns Morking, Bultimore, Maryland 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

11 9 1999

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death NICKEL OO AM 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death N 1 TIMORE STREE NK If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Dafe of Birth (Month, Day, Year) Min 1 M 2 F Months Days Hours Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 1 Yes 2 10 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Race - American Indian, 11. Meritel Sfefus Black, White, etc. 1 Never Married 2 Married 1□ Yes 2□No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WESTERN 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) UNKNOWN NDREW 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BACTO. AMELA ABINSKI 20b. Placa of Disposition (Neme of cemetery, crematory or other place) WENUE. 20c. Location - City or Town, State 20a. Method of Disposifion 1 Buriel 2 □ Cremation 3 □ Removal from State ST. STANISLAUS 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licansee KACZOROWSKI HOME FUNERA DUNDACK BALTO MD RC rorawkki 2 12 23a. Part1. Enter the disease, or complications that diused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Tasmo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 D Residence 8 Other (Specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

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Completed

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at

Pages 1 end 2 should be filed within 72 hours after death nent of Health and Mantel Hygiene.

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permit. Page Department of Important: If any injury or

Baltimore, Maryland 21215-0020

with the Marylend

Examiner

Physician/Medical þ Completed Be 2

27. Manner of Death

1 DNatural

2 Accident

3 Sulcide

(Check on

29b. Signature and title of certifier

29a. Certifier

4 ☐ Homicide

physician end s the burial-transit requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, attending pl signed by the a should I certificate has b lirector, page 2 s after death.

Director: After this certifica funeral Certification: in 24 hour. the Funeral Direc-

To the Fune completely f To the Vithin 2

State Registrar

Medical

NichARO 31. Date filed (Month, Day, Year)

1 9 1999

JAN

5 Pending investigation

6 Could not be determined

32. Registrar's Signature

1600

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Plece of Injury - At home, ferm, sfreet, factory, offica building, etc. (Specify)

& XIIV

28c. tnjury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29 License number

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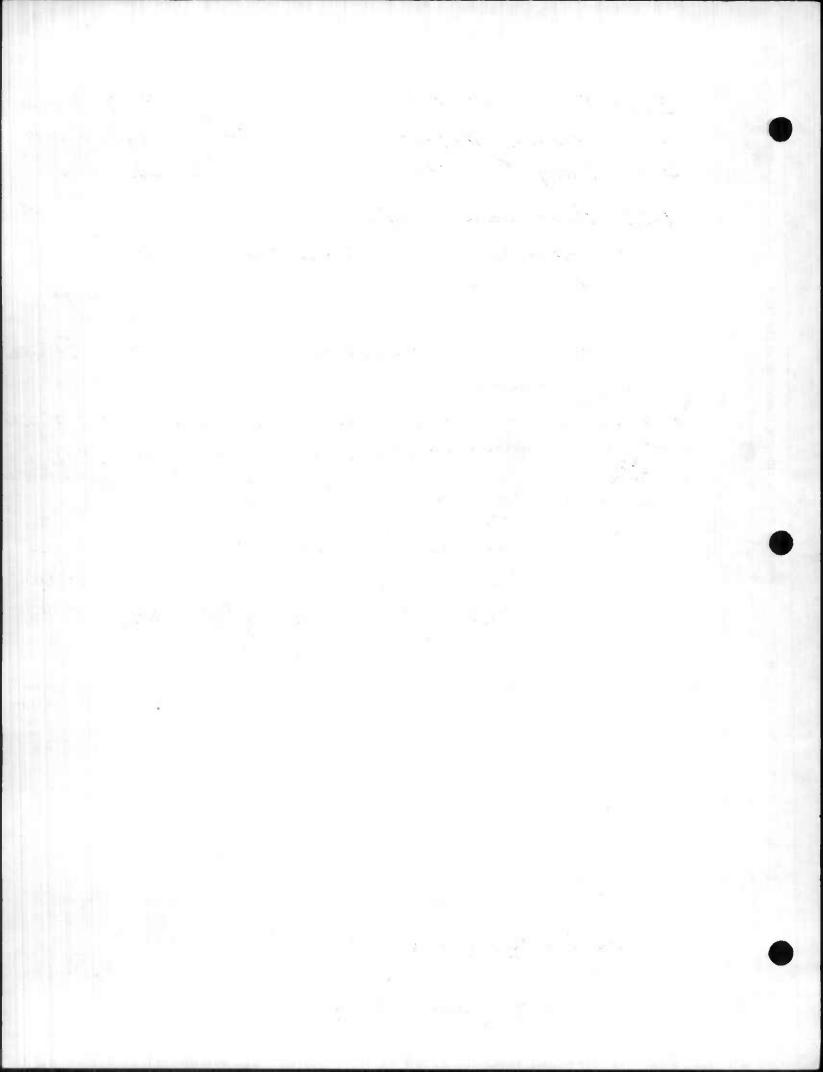
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1 Yes 2 No

28d. Describe how Injury occurred

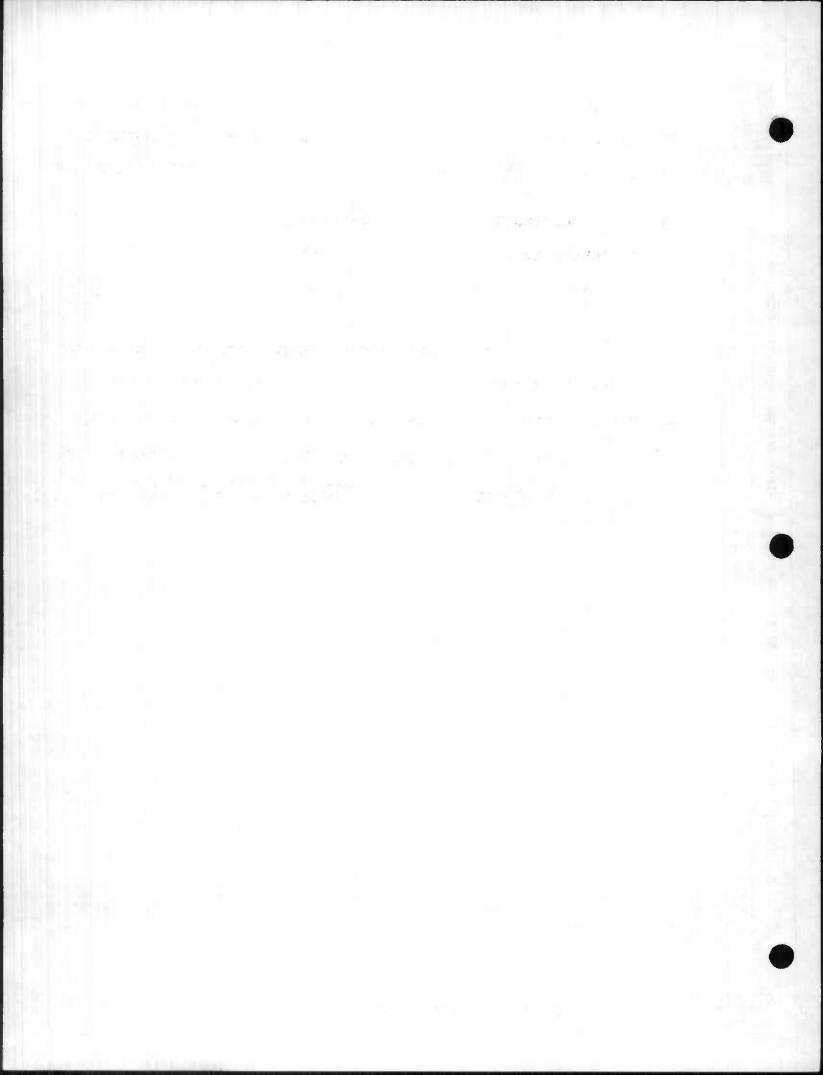
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)



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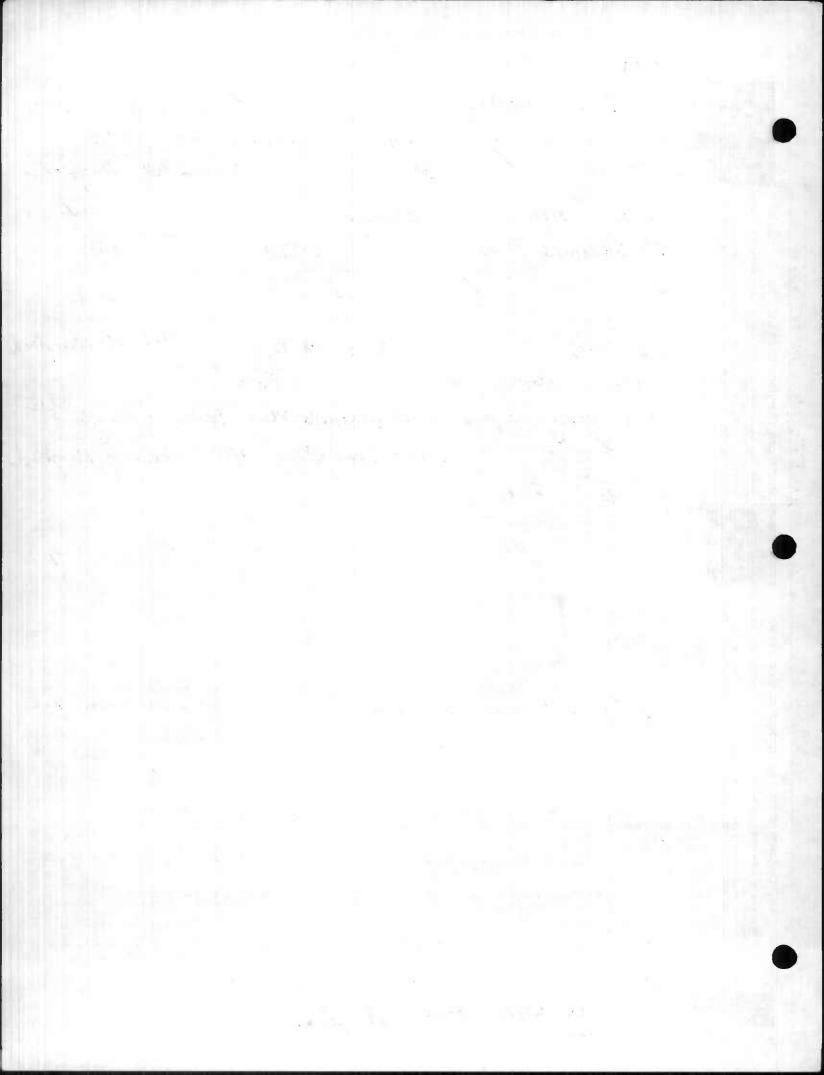
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Item 7 Per FH Film G767 1-19-99 rja Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Setella Nottage pm Sanuary 12, 1999 4b. City, Town, or Location of Deeth 9 de. County of Death · /Medical 4e Facility Name (If not Institution, give street and number Examiner Baltimore City LENESIS Eldercare Caton Manor Hours Min. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 216-34-9486 9. Bethplace (State or Foreign 6. Sex 1□ M 2 F 6/Yrs. Months Director Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside Oily Limits Battimore 1 DYes 2 No Maryland Directo 10 Street end Number 138 W. 10f. Zip Code 10g. Citizen of What Country2 item 27 is marked other than "naturel", or items 23s or other traumatic event, the Modical Exeminer must be a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Specify: Black 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) of Maryland College (1-4or 5+) Worker 18. Mother's Neme (First, Middle, Meiden Sumeme) Be ould be f Thomas 19e. Informent's Neme/Relationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Westhills PKWY, Baltimore, Manyland Nottage of Health 20c. Location - City or Jown, State 20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other p Date 1 ☐ Burial 2 MCremetion 3 ☐ Removal from State remator 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funere Service Licenses tarke 23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Cerebovercular fecident Immediate Ceuse (Final disease or condition resulting in death) /Medical 1Da Examiner Due to (or es a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) P.O. Box 68760. Due to (or as a consequence of): Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? Cevelo Vorinler Senden 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings evailable prior to completion of ceuse of deeth? 24a. Wes an autopsy performed? Completed typer tension 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth

1 Natural
2 Accident 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No hours efter death. 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier Kymee MI) Alterding Doctor D21684 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) RITCHIE LOWY, PASADBNA, 8109 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State

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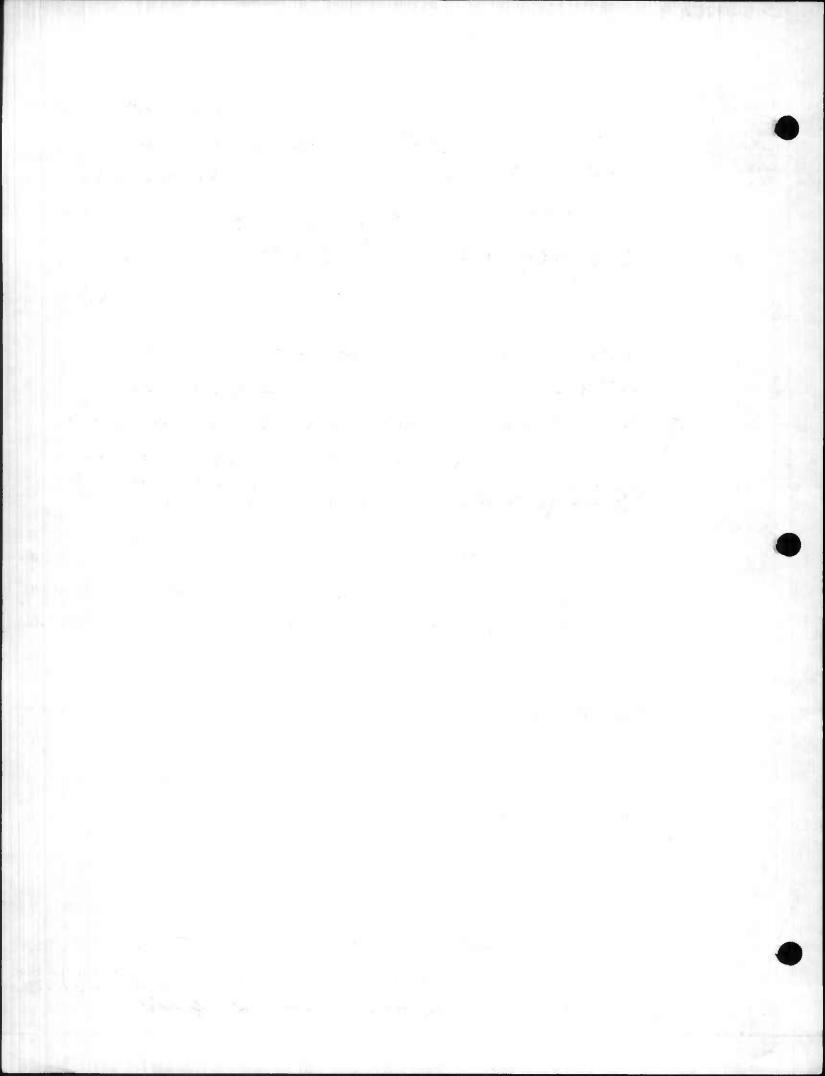
Registrar

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Physician /Medical	1. Decedent's Name (First, Middla, La EUZabeth	orwig			2. Date of Dea Month	th Day	Voor	e of Death
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ed at	Usual Residence of Decedent  10e. State 10b. County		, Town or Location	imore ci	Tv			te City Limits
ted by Funeral Director	10e. Street and Number			ip Code	1	log. Citizen of W	hat Country?	
by Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever In U, Amed Forcas? 1  Yes 2 No !! Yes, Giva		edant of Hispanic Origin? (Secify Cuban, Maxican, Puerl	pecify Yas or No- o Rican, etc.)	14. Race	- American India White, atc.	
Completed b	3 Widowed 4 Divorced  15. Decedent's E (Specify only highast gra  Elementery/Secondary (0-12)	completed) College (1-4or 5+)		ork done during most of wor use retired)	king	16b. Kind of Bus	siness/industry	
To Be Cor	17. Father's Name (First, Middle, Last, Robert Mc	Lewee	54	18. Mother's Nar	ne (First, Middle,	Cloth Maiden Sumame Run G	"	
Cities Italian	20a. Method of Disposition	) rwi G 20b. P	2517 Gace of Disposition (No	SS (Street end Number or RU RICACOR RI amme of	BALT		Grate, Zip Code)	
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Examiner		. Myocare		infarction	CAC	ute)	5	hours
dicai	Saquentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that infilted events resulting in death) Last	· Aspirati	as a consequence of as a consequence of	heumonia	P		5	hours
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should be	31				24a. Was a perfor	in autopsy mad?	24b. Were auto available p complation of death?	rior to
ector, page Be Con	25. Was case referred to medical			26. Place of Dec	1 ☐ Y	es 2KNo	1 🗆 Yes	2 No
J Gire	examiner? 1 Yes 2 No  27. Menner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 0 28b. Time of Injury M	Other	loma 5 Rasid			
lled in by the funera Certification:	3 Sulcida 6 Could not b 4 Homicide determined	building, etc. (Specify			City or Tow			
completely filled  Medical Ce	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my knowniner: On the basis of exeminate and manner stated.	vledge, deeth occurred ion end/or investigetio	d et the time, date and place n, in my opinion, death occu	, and due to the c rred et the time, d	ause(s) end <i>mer</i> lete and plece, e	ner es steted. nd due to the ceu	use(s)
woo	29b. Signature and title of certifier	Inter		P 1 2 5 5 8			7,1999	
)	30. Name end eddress of person who	completed cause of death (Item	23e) (Type, Print)	Berer			1 0	una Rha



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 13 1999 10:40 AM OH January /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Arundel Arundel Anne Hospital GlenBurnie If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Devs Hours Months 1 ■ M 2 X F Yrs. Director 253-49-1163 92 APRIL 21, 1906 KOREA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ANNE ARUNDEL MARYLAND MILLERSVILLE 1 ☐ Yes 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Norma 23a 8289 ELVATON ROAD 21108 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Yeer or Dates: 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 'natural', or 1 Yes 2 No Specify: Specify à 3 Widowed 4 ☐ Divorced KOREAN Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) UNKNOWN HOMEMAKER OWN HOME 17. Father's Name /First Middle Last) 18 Mother's Name (First Middle Maiden Sumame) Be 90 and Mental UNKNOWN UNKNOWN Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) mportant: If Ilem 27 any injury or other tr 8289 ELVATON ROAD, MILLERSVILLE, MARYLAND KWANG SIK OH (SON) 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition b 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 1/15/99 4 ☐ Donation 5 ☐ Other (Specify) LAKEVIEW MEMORIAL PARK SYKESVILLE, MARYLAND to of Fatheral Servido Licensee 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A. 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only the ceuse on each line. GLEN BURNIE, MARYLAND 21061 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Due to (or es a consequence of): Examiner physician and the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 88 USB Po ed by the a 23b. Did tobacco uss contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed b þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? been signal 24a. Was an autopsy performed? Completed page 2 s has 2 2 No 1 Yes 2 No Attending Physician: Be 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 10 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 TYes 2 No after death. investigation Director: / 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò To the Hospital within 24 hours a To the Funeral Completely filled Hospital hours Certifying Physician: To the best of my knowledge, death occurred at the fime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29b. Signsture and title of cartifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rsv 6/95

Baltimore, Maryland 21215-002

Box 68760

P.O.

Records,

Division of Vital

MM

301 Hozarta) 32. Registrar's Signature

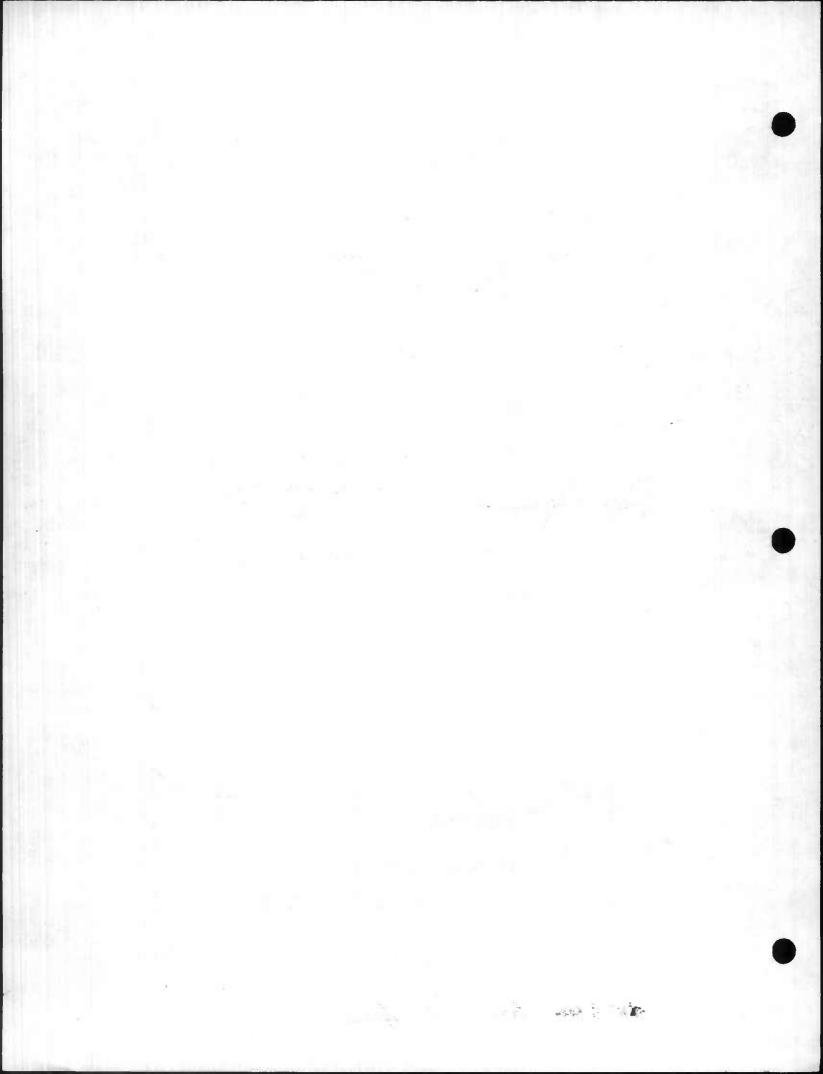
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Name and address of person who completed cause of death (Item 23a) (Type, Print)

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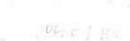
31. Date liled (Month, Day, Year)

JAN 1 9 1999



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edical	NORA MARIE PO		ther)			4b. City, Town, or Lo	JANUARY cation of Deeth	13, 1 4c. County		
iner	W 22 - 20 - 10 1 - 20 - 10 1 - 20 - 10 1 - 20 - 20		Doiy							
1	CHESAPEAKE MA  5. Sociel Security Number 6		7. Age (In yrs. I	est birthday)	If Under 1 Year	ARNOLD if Under 24 Hrs.	8. Dete of Birth		9. Birthplece (State or Fore Country)	
	502-28-4773	1□ M 2□XF	91	Yrs.	Months Deys	Hours Min.	JAN 3,1		Country) WILLMAR, MN	
	Usuel Residence of Decedent		91				ו פר אמר	300	WILLIFIAR, PIN	
	10a. Stete 10b. County		10c. City	, Town or Loc	cation				10d. Inside City Lim	
Director	MARYLAND ANNE A	ARUNDEL		ARNOI	LD				1 ☐ Yas 2 ∏	
5	10e. Street end Number				10f. Zip Code		109	. Citizen of V	of What Country?	
runeral L	305 COLLEGE PARK	YAW			2101	2		U.S	. A .	
	11. Maritel Status	12. Wes Dece	dent Ever in U,:		Ves Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	14. Race - American indian, Bleck, White, etc.		
	1 Never Married 2 Married		2 TNo		☐ Yes 2☐ No	Specify:		Specify		
	3 X Widowed 4 □ Divorced	Yeer or De			41			WHITE		
	15. Decedent's (Specify only highest of			(Give i	ent's Usuei Occup kind of work done	during most of working	ing 16b. Kind of		Business/Industry	
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0		(Tune Print)		10h Maile	a Address /Cira-i	ANNA O		City or Tour	or Town, State, Zip Code)	
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	ROBERT POPE (SON 20e. Method of Disposition	1)	20b. Pl		INLYNN sition (Name of	VIEW RD -			City or Town, State	
	1 Buriel 2 Cremetion 3									
	4 □ Donation 5 □ Other (Spe		SKY			GARDENS 1	/19/99	PORTLA	ND, OR.	
Important in any	21. Signature of Funeral Service Lic	de 10		Η̈́Ū	Name end Addre	NERAL HOM	E, INC.			
	1200	المناهر		41	.07 WILKE	NS AVENUE	-BALTIMO	RE, MD	21229	
	23a. PertY. Enter the diseese, or co shock, or heert failure. List on	ly one cause on ea	ach line.				st,	Approximate intervel Between		
		1-		1	)	nia Direce			Onset end Deeth	
	Immediate Cause (Final disease or condition resulting in death)	· 1750	water		neumo				1 Week	
4		100	Due to (or	as a conseq	uence of):	i D.	and		1 Week	
THE PERSON	Part of the last o	b. ofelva	mag	1/2	5	· Orre	-		7/3000	
Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying		Due to (or	ras e conseq	uence of);					
dicai	cause. Enter Underlying Ceuse (Disease or injury that injuried events)									
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Physician/M	Pert il. Other significant conditions	contribution to do	ath but not reco	ulting in the us	iderlying cause of	ven in Pert I	23h Did toh	acco use co	ntribute to the causs of dec	
nys	ort ii. Other significant conditions	Continuuting to dea	an but not resu	was as the nu	reallying cause gr	ent in Fest t,	1 Yes	1	3 Probably 4 Unkr	
by P							1 180	Shorten		
							24e. Wes an	autopsy	24b. Were autopsy finding	
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dist.							1 ☐ Yes	2 × No	1 ☐ Yes 2 ☐ No	
)	25. Was case referred to medical					oc Blass of Decir			TILITIES ZILINO	
0 00	exeminer?	Hospitel:	notiont OD	ED/Out-ation	t 3 DOA Oth	26. Plece of Deeth	me 5 Realden		or (Specify)	
	27. Manner of Deeth	28e. Date o	f Injury	ER/Outpatien 28b. Time of	1 3LI DOA	4 KU Nursing Ho	28d. Describe hov			
5	1 Neturel 5 Pending investigat	(Mont/	h, Dey Year)	Injury		rk?  Yes 2□No				
-	3 ☐ Suicide 6 ☐ Could not		of injury - At ho	me, ferm, stre	eet, fectory, office		28f. Location (Stre	et end Numb	per or Rural Route Number,	
Certification:	4 Homicide	buildin	g, etc. (Specify	)			City or Town,	Stete)		
5	29a. Certifier ( Certifying )	Physician: To the I	best of my know	wledge, deeth	occurred at the tir	me, dete end plece,	end due to the ceu	use(s) end me	enner es stated.	
OIC	(Check only 2 Msdical Ex	aminer: On the ba	sia of examinet	ion and/or inv	estigation, in my o	pinion, deeth occurr	ed et the time, det	e end place,	and due to the cause(a)	
one) and menner stated.									d (Month, Dey, Year)	
5	29b. Signeture end title of certifier									
2	29b. Signeture end title of certifier	1) Alto.	edi.	Docto	1.	21684		1-15	5-1999	
Me	29b. Signeture end title of certifier		rding			21684		1-15		
Me	29b. Signeture end title of certifier  Culculated  30. Name end address of person wh	no completed cause	of deeth (Kem	23e) (Type, I	Print)		DADV		5-1999	
tate	29b. Signeture end title of certifier	completed cause	of deeth (Kem	23e) (Type, I	Print)		PARK -		5-1999	



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THE STREET OF THE STREET

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEM: #5 PER F.H. G767 1-15-99 WR. Reg. No 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Edward Timothy Powers January 4, 1999 4b. City, Town, or Location of Death 4c. County of Death 6:30an 4a Facility Nama (If not Institution, give street end number) Fort Howard Baltimore VAMHCS Fort Howard Division If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number 8. Deta of Birth (Month, Day, Year) 6. Sex 7. Aga (In yrs. last birthdey) Birthplece (State or Foreign Country) 1 M 2 F Months Days Hours Min Yrs. November 6, 1925 Washington, D.C. 212201783 Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Maryland Baltimore City Baltimore 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4513 Arabia Avenue 21214 USA 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 14 Rece - American Indian 11. Marital Stelus Biack, White, etc. Armed Forces: 1 X Yas 2 No If Yas, Giva Year or Datas: W 1 Navar Marriad 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) WA 12 Carpenter Construction Industry 18. Mothar's Nama (First, Middle, Maidan Surname) 17. Fathar's Nama (First, Middla, Last) Farl Powers Margaret Shugrue 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Dennis J. Powers (Nephew) 4513 Arabia Avenue Baltimore, Maryland 21214 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 XBurial 2 Cramation 3 Ramoval from Stata Garrison Forest VA Cem. January 12,1999 Owings Mills, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensee 22. Nema and Addrass of Facility Lassahn Funeral Home, Inc. 23a. Part1. Entar tha chasas, or complications that sausad tha death. Do not anter the mode of dying, such as cerdiac or raspiratory errest, and shock, or haart tailure. List only one cause on each line. Approximata Interval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting In daath) Cardiac Respiratory Failure Due to (or as a consequance of): Lung Cancer Months Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Diseesa or Injury that initiated evants rasulting in daath) Last Dua to (or es e consequenca of): Prostate Cancer Months Due to (or es e consequance of): 23b. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 ☐ Probably 4 Minknown 1 ☐ Yee 2 ☐ No 24b. Wara autopsy findings available prior to completion of ceusa of death? 24a. Wes an eutopsy performed? 1 ☐ Yas 2 ☐ No 1 ☐ Yes 2 No 25. Was case refarred to madical exeminer? 26. Place of Death (Check only ona) Hospital: Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 ☐ Yas 2 ☐ No No Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Mapnar of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Naturai 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida

physician and the bunal-transit The law requires that the death certificate be executed 88 attending 950 Po signed by the a is certificate has director, page 2 or Attending Physician: this funeral After after death.

Director: Aft
d in by the fur 6

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

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Examiner

Physician/Medical

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Certification:

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29e. Certifier

(Check only one)

**Funeral** 

**Director** 

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7 is marked other traumatic event, I

ò

1 and 2 should be filed within 72 hours after

Mental

It Health Item 27 i

**Physician** /Medical

Examiner

Jemit. Pages 1 Department of H

Baltimore, Maryland 21215-0020

Name: Edward T. Powers

Division of Vital Records, P.O. Box 68760, 24 hours after Funeral Directions of the Funeral Direction of the Funer completely To the To the To the I

> State Registrar

29b. Signature end titla of certifiar Alliedini/

Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, end due to the causa(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, deta and place, end due to the cause(s) and manner stated. 29c. Licansa number

29d. Data signed (Month, Day, Year)

D51493

1-4-99

30. Nama and addrass of person who completed ceusa of daath (Item 23a) (Type, Print)

9600 North Point Road, Fort Howard, MD 21052 Anwer H. Siddiqui, MD

31. Date filad (Month, Day, Yaar) 32. Registrar's Signetura JAN 1 5 1999

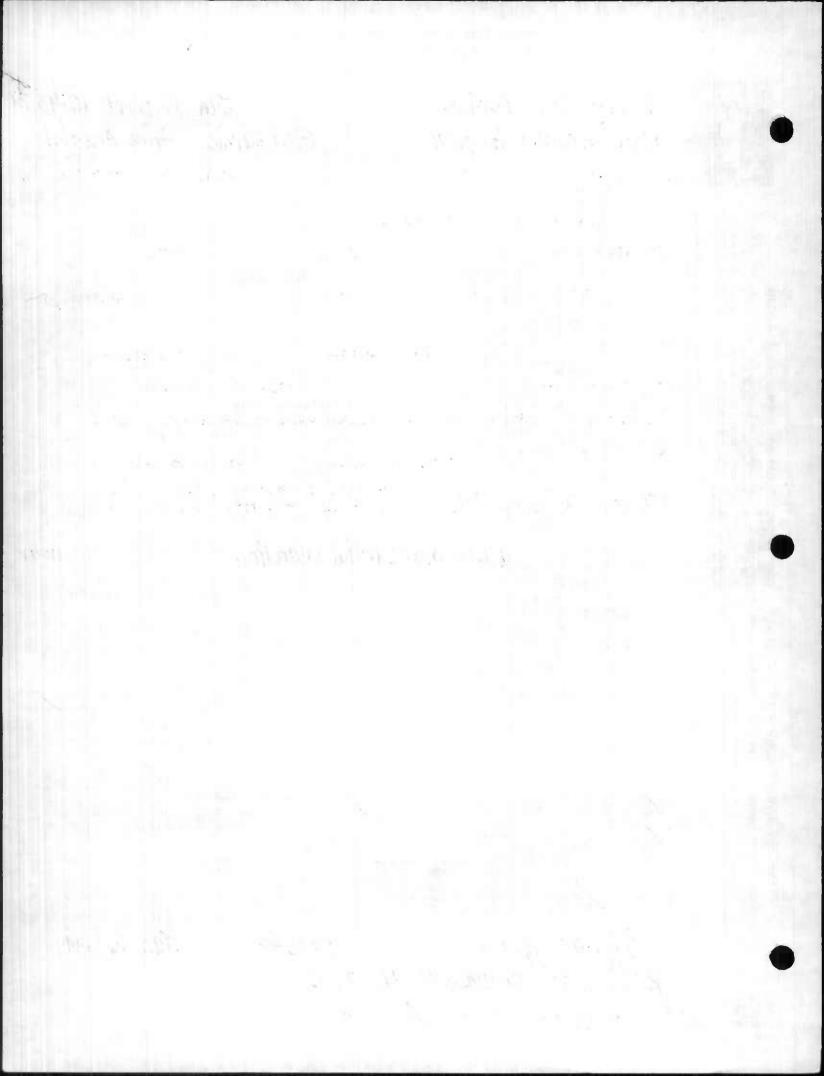
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State of Maryland / Department of Health and Mental Hygiene 9 0 8

							yları		rtificate		Death		Reg. No.	) (1	000
	Physicia: /Medica		1. Decedent's Nam Bob	by R		Perdu	e					2. Date of De	Pay	1999	3. Time of Death 10:43 AM
	Examine	r	4a Fecility Name (	h Aru	, give street an INCL 6. Sex	HOSPI	tal	ast birthday)	If Under	1 Year	4b. City, Town, or L G/en B( If Under 24 Hrs.	CATION of Death  I MIC  8. Date of Bird  (Month, Da	An	nty of Death  Ne A  9. Birth	rundel place (State or Foreign
L	Director		214-66-3 Usuel Residence o		155 W SC	) F 45	5	Yrs	Months	Days	Hours Min.		1954	Nort	th Carolina
	Anyland f show ed.at	50	10a. State	10b. County	rundel			, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
		al Director	10e. Street and Nu 1218 Wil	mber			J1C1.	Duri	10f. Zip	Code 1061			10g. Citizen	of What Cou	Α
020	urs after des af, or items Examiner m	by runeral	11. Marital Status 1 Never Marr 3 Widowed		ed 1   If Ye	Decedent Eve ed Forces? Yes 2 No es, Give r or Dates:	er in U,	S. 13.	Was Deced If Yes, spec		Ilspanic Origin? (Sp en, Mexican, Puerto Specify:	Origin? (Specify Yes or No- an, Puerto Rican, etc.)  14. Race - American Black, White, etc.  Specify: White			etc.
21215-0020	within 72 ho ens. then "netur the Medical	Completed	(Spec	15. Decedent cify only highes ondary (0-12)	t grade comple	eled) ege (1-4or 5+)		16e. Dece (Give life. Fence		rk done se retire	eation during most of work d)	king		Business/in	1.301.5
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imore,	altimore, mit. Pages 1 a pertant of Hea portant. If Nem y Injury or othe			position  Cremation  5 Other (S)		from State	CE	lace of Disponentery, cre	matory or o	ther ple	1	Date /21	20c. Location	carol	
Ba	Physician /Medical Examiner	Jeu	21. Signature of Fundamental State of Fundamental State of State o	he disease, or in failure. List	Haro complications only one cause	acute	n	n. Do not en	Harde 12 Ri ter the mod	sty due e of dyin	ss of Facility Funeral Ly Ave. A ng. such as cardiac I Nfarch	nnapoli or respiratory a	A. S. MD	2140	Approximate Interval Between Onset and Death ONE hour
Box 68760,	tificate be ig physicia es the bu	8	Sequentially list or if any, leeding to ir cause. Enter Unde Cause (Disease or that initiated event: resulting in death)	enditions, nmediate erlying injury s Last	c			as a conse							
P.O.	that the death cered by the ettendin	y Physician/M	Part II. Other signi	ficant conditto	na contributing	to death but r	not resu	ilting in the u	underlying co	ause giv	ven in Part I.		tobacco use Yes 2 N		to the causa of death?
il Records,	The law requing ate has been single 2 should	Completed by						÷				24a. Was perfo	an autopsy ormed?	a c	Vere autopsy findings vallable prior to ompletion of cause ideeth?  Yes 2 No
of Vital	delan: certific rector	0 00	25. Was pase reference examiner?		Hospital:	1 🗆 Inpatient	2 🗆	ER/Outpatie	nt 30% DC	Oth	26. Piece of Dee			Other (Spec	i(v)
ion of			27. Menner of Deel 1 Natural 2 Accident	h 5 Pendin Investig	9	Date of Injury (Month, Day Y		28b. Time of Injury		8c. Inju		rsing Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  No			
Division	To the Hospital or Attending Ph within 24 hours effer deeth. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determ	ned 200.	28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)					28f. Location ( City or Ton	Street and Nu wn, State)	imber or Ru	al Route Number,	
	To the Hospital within 24 hours of To the Funeral completely filled	edical	29s. Certifier (Check unity one)		Examiner: On		kaminat				me, dete end plece pinion, death occu				
	To the Within Comit	M	29b. Signature and	full !	ruggs	MÀ					28640		Jar	ned (Month	Day, Year)
	7		30. Namp and add	BOX 2	8 Completed	DWNS	th (lifer	(Typ)	1000 2	103	2	Jeffrey	Briggs	s, MD	

State Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month JANUARY **Physician** CATHERINE MARY PRIMROSE 14, 1999 08:45 PM /Medical 4e Facility Neme (If not institution, give street and number)
Saint Joseph Medical ( 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore 5 Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2⊠ F Months Days Hours Min Yrs. 216-05-0936 82 Director 11,1916 Aug. Maryland Usuel Residenca of Deceden 10a Stete show 10h Count 10c City Town or Location 10d. Inside City Limits 1 Yes 2 No Director 28a-f Maryland Baltimore N/A 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 munt be Berns 23a 3300 Lawnview Avenue 21213 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "naturef", or 1 ☐ Yes 2 TNo Specify: White à 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiens. Elementary/Secondery (0-12) College (1-4or 5+) Homemaker 5th Grade Own Home permit. Pages 1 and 2 should be tiled.
Department of Health and Mental Hygie Important: If Nem 27 is marked other any Injury or other traumatic event. B 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Charles Gilland Catherine Winkler 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Linda L. Hooper (daughter) 9519 Perry Brook Ct., Baltimore, MD 21236 20b. Plece of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 Burial 2 Cremetion 3 Removel from Stete Moreland Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 1/18/99 Baltimore, Maryland 21. Signature of Funerel Service Licensee 22. Name end Address of Facility Schimunek Funeral Home, Inc. a an 9705 Belair Road, Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tallure. List only one cause on each line. Approximete Interval Betwe Onset and Death **Physician** CARDIAC FAILURE STATUS POST OPEN /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner HEART SURGERY 6 HOURS physician and the bunal-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): CORONARY ARTERY DISEASE / Box 68760 that the death certificate be Physician/Medical Due to (or es e consequence of): for use as AORTIC STENOSIS YEARS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 0 the t Ves 2 No 3 Probably 4 Unknown 2 CHRONIC GASTROINTESTINAL BLEEDING 0 signed t Records, by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed CHRONIC OBSTRUCTIVE PULMONARY DISEASE peen page 2 s has 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitel: 1 

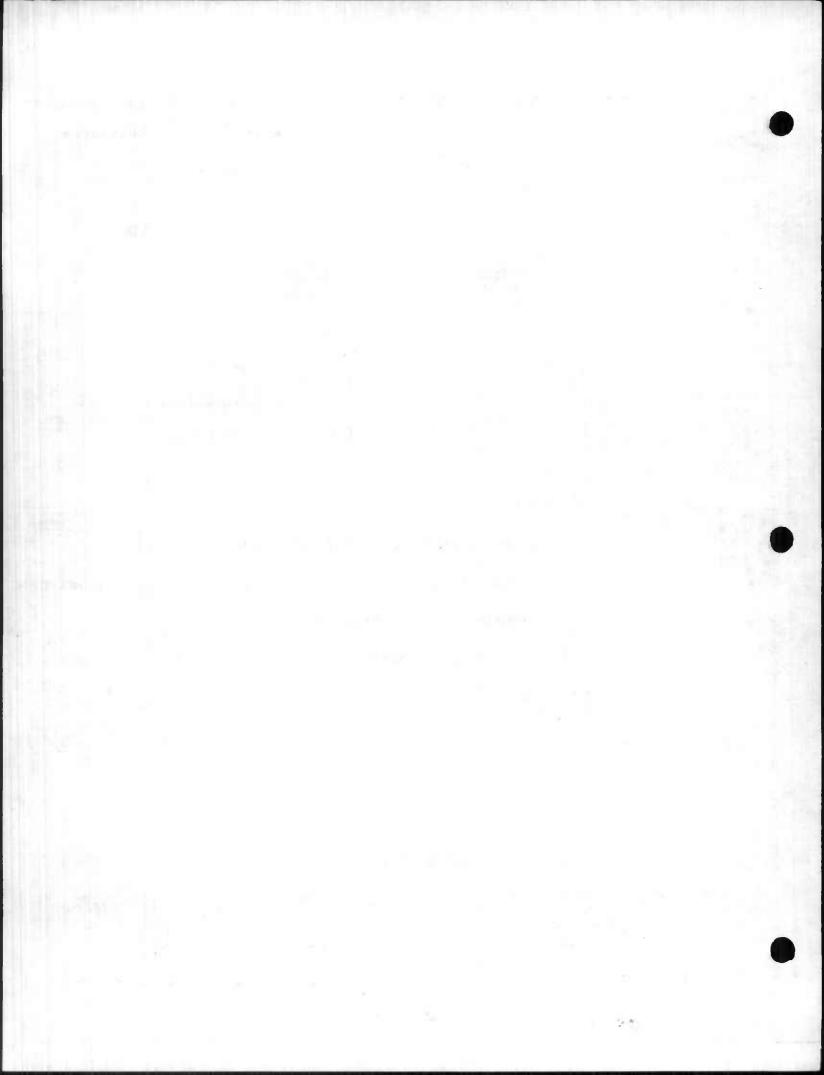
Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes No 2 ER/Outpatient 3 DOA this 27. Menner of Death 28e. Dete at Injury (Month, Day Year) 28b. Time of 28c. Injury st Work? 28d. Describe how injury occurred Certification: 5 Pending investigation or Attending 1 XNeturel To the Hospital or Attendify within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu death. 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certile 99 38655 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) STEWART FINNEY, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar 31. Date tiled (Month, Day, Year)

JAN 1 9 1999

32. Registrar's Signeture B. Sparks

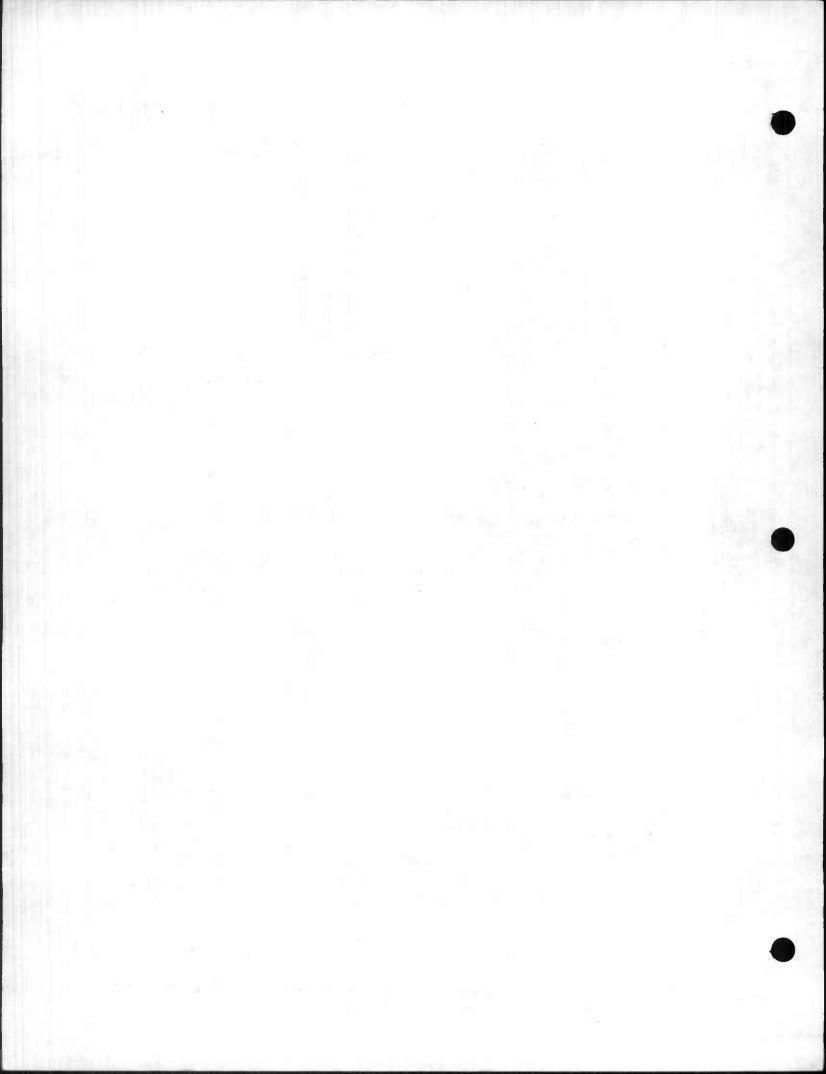


WRC 99-0251-025 ALBERT W.

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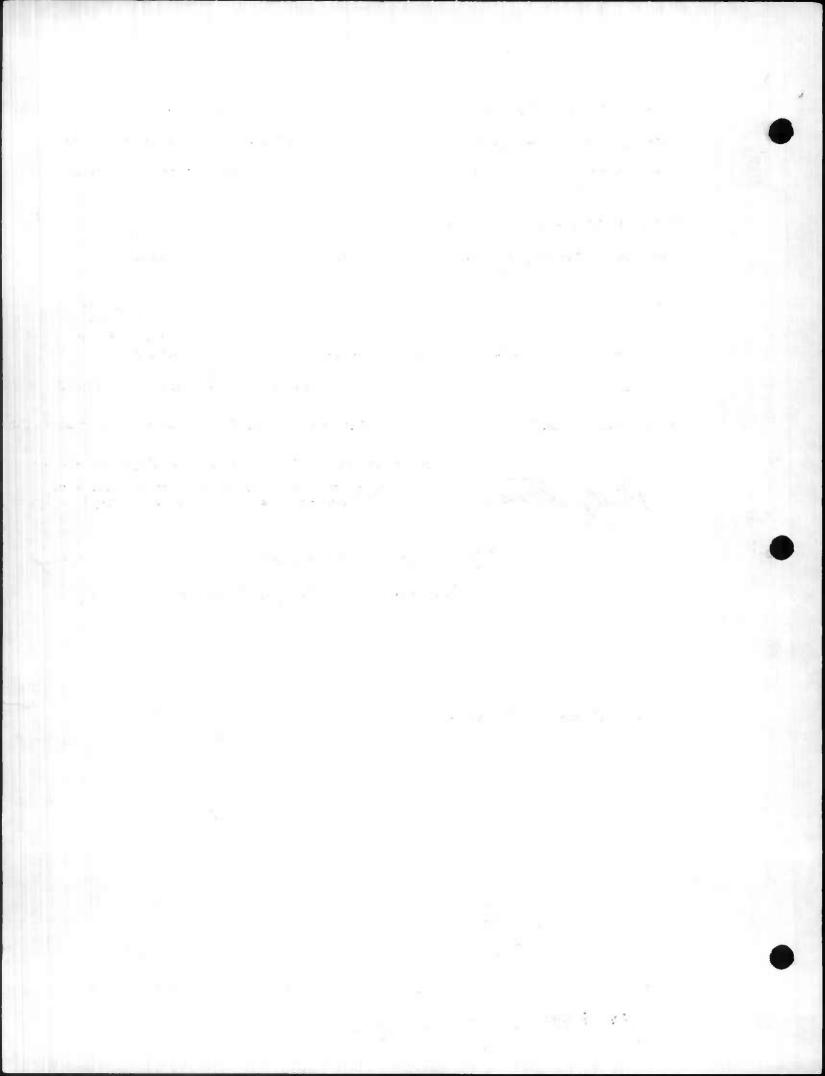
State of Maryland / Department of Health and Mental Hygiene 9 9 0 2

P	FINGST	EN		Ce	ertificate o	f Death	7	B	eg. No.		0000
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	hysician /Medical	A1	bert Warren	Pfin	gsten			JANUARY		999	3:31 PM.
	Examiner	4a Facility Neme (If not institution, gi	ve street and number)			4b. City, To	own, or Lo	cation of Death	4c. County	of Death	
			ORIAL HOSPITAL		.1 #11-4-4	HAVRE				ARFOF	
	ineral rector	387-18-9615	Sex 7. Age (In yr. 77	s. last birthday Yrs.	Months De		Min.	8. Date of Birth (Month, Day, MAR 6,	1921	9. Birthp Cour W1 S	place (State or Foreign http) CONSIN
pue	ž	Usuel Residence of Decedent  10a. Stete 10b. County	10c. (	City, Town or I	ocation					1	IOd. Inside City Limits
he Mery	be notified a Director	MD Harfor	d	Abing	1						1 ☐ Yes 2 ☐ No
ath with	or items 23s or 28s-f show imper must be notified at f Funeral Director	100. Street and Number 1004 Hookers M			10f. Zip Cod 2100	)9	-21			SA	
Z I Z I D-UUZU d within 72 hours after death with the Meryland jiens.	6	11. Marital Stetus 1 Never Merried 2 Merried 3 Widowed 4 MDivorced	12. Was Decedent Ever in Amped Forces?  1 Eyes 2 The If Yes, Give WW Year or Dates:		Was Decedent of If Yes, specify C			cify Yes or No- Rican, etc.)	14. Race - American Indian, Bleck, White, etc.  Specify: White		
22 h	t, the Medical Ex.	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dec	edent's Usual Oci	cupation ne during mos	st of working	na	16b. Kind of B	usiness/In	dustry
within one.	un de	Elementery/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use rel	rired)					
2 6			AL .	car	penter	10.14.0	. de Meses	AFT A B A'-d-M- I			ction
	To Be	17. Father's Neme (First, Middle, Las George Pf				18. Moth		(First, Middle, Ma 1a Omic		ne)	
2 sh	E	19a. Informent's Neme/Relationship	(Type, Print)	19b. Mai	ling Address (Str	eet and Numb	ber or Rura	Route Number	, City or Town,	Stete, Zip	Code)
a dia	n 27	William P. Pfi		706	E. Bro	adway	Be	1 Air		2101	4
wemit. Pages 1	int: If their iny or off	20a. Method of Disposition  1 Burial 2 A Cremation 3 [ 4 Donation 5 Other (Special Content of the Content of th	Demousl from State	cemetery, ch	position (Name of ematory or other p rematory	place)	01/1		20c. Location Baltime		
permit. Departm		21. Signeture of Funeral Service Lice Edward A. G.	egorchik	1	Cremati 299 Fre	dress of Facil	ciet	y of N	imoro	nc.	21228
		23a. Part1. Enter the disease, or son shock, or heart feilure. List on	I specie							, III	Approximate Interval Between
Hitless be executed	ng physician and sa the burdelfraneit well call Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. Hypothern Due to b. Gastroink Bue to c. Cardova Due to		er dis			uppa u Ath	resu	lenta	
de st	d by the attendine tetached for usa	Pert II. Other significant conditions		esulting in the	underlying cause	given in Part	J.	23b. Did to	bacco use co	ntribute t	o the cause of death?
hatt	Ph detec							1 🗆 Y	es 2 No	3 Pro	bably 4 Tunknown
inger v	page 2 should be determined by P			H				24a. Was a perform		av	ere autopsy findings allable prior to impletion of cause death?
The ia	page 2							162 Y	es 2 No		ZYes 2□ No
	rector, pag	25. Wes case referred to medical				26 Piac	e of Death	(Check only on		1	200
Physician:	direct O	examiner? }∑XYes 2□ No	Hospitel: 1 Inpatient 21	ZI ER/Outpatie	ent 3 DOA	Other		ne 5 Reside		ner (Specia	(v)
or Attending	ther death.  Nrector: After this in by the funeral di	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	home, ferm, s	of 28c. lr	njury at Vork? Yes 2	2No 2	b la	ow injury occur	red a	tposed
To the Hospital within 24 hours	Completely filled in by Medical Certifi		nysician: To the best of my lo miner: On the basis of examin and mapner stated.								
To the	Me	29b. Signeture and title of certifier	011		29c. Lice	ense number		2	9d. Date signe	d (Month,	Dey, Year)
	2	K	1 4			0.	.C.M.	E	JANUARY	17,	1999
BX	1	30. Name and address of person who	/		n Street	r. Rali	timor	e. Mars	land 21	201	
	State	31. Dete filed (Month, Day, Year)	1999 32. Regist dir's Sign	nature		als	CHIOL	C, Floury.	Land 21	401	7 7 3
R	legistrar	JAN T	1004			(					



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		State	of Marylar	•	nent of I icate of		d Mental Hy	gieney 9 Reg. No.	UUI	803
Dharaisis	1. Decedant's Name (First, Middle,	Last)					2. Data of De Month	ath Day	Year 3.	Time of Death
Physician /Medical Examiner	Mary Elizabeth  4a Facility Nama (If not institution,					4b. City, Town,	January or Location of Deat	y 17, 19	99 10	0:00 A.M.
	3310 Benson Ave	enue, un	it 303			Lansdow			more Co	
Funeral Director	218-18-3967	5. Sex 1 □ M 2 ☑ F	7. Aga (In yrs. 87		Under 1 Year onths Days		fin. 8. Date of Bir (Month, De JAN.5,	th by, Year) 1912	9. Birthplace Country) (arylan	(State or Foreign
pu *	Usual Residence of Decedent  10a, Stata  10b. County		10c. Ci	ty. Town or Location	on				10d. I	nside City Limits
hours after death with the Maryland urel, or thems 23s or 28s-1 show Examiner must be nucled as ed by Funeral Director	Maryland Baltim	0.20		nsdowne						I □ Yes 2 🕅 No
vith the Maryland or 28a-f show or noulled	10e. Street and Number	ore	Lia		Of. Zip Code			10g. Citizan of V	Vhat Country?	
D To	3310 Benson Aver	nue. uni	t 303		21227			U.S.A.		
of, or items 23s or items 23s or items	11. Marital Status  1 Never Married 2 Marrie  3 🖫 Widowed 4 Divorced	12. Was Dec Armed F	edent Ever in U orces? 2 🔯 No ive				(Specify Yas or No uarto Rican, etc.)		e - American Ir k, Whifa, atc.	
naturel', bulcal Erro leted by	15. Decedent's		Jates.	16a. Decedent'	s Usual Occu	nation		16b. Kind of Bu	White usings/Industr	
or than nature of the transfer	(Specify only highest Elemantary/Secondary (0-12)	grade completed)	1-4or 5+)	(Give kind lifa. DO f	of work done VOT use retire	during most of	working	Army-Ai		•
ther the	12	N/A		Account	t veri			Exchang		
c avent, o Be C	17. Father's Name (First, Middle, La Edward	C.		Glee		18. Mothar's l	Name <i>(First, Middle</i> Fra	, <i>Maid</i> en Sumem anklin		mith
Tarri T	19a. informant's Name/Relationshi	p (Type, Print)		19b. Malling A	ddress (Stree	t end Number or	r Rural Routa Numb	er, City or Town,	Stete, Zip Coo	de)
If item 27 is or other trac	Ruth Brown (da 20a. Mathod of Disposition	aughter)		102 N. Placa of Dispositio	n (Neme of	_	otF, Glo	en Burni 20c. Location -		
ant: If	4 Donetion 5 Other (Spe			dowridge	Mem.	Park	JAN.21	Elk Ridg	e, Mar	yland
Important: I eny injury o	21. Signeture of Funeral Sarvice Li	Harl		S	terlin		n-Schwab Ave. Cato			
nysician Medical xaminer	shock, or heart failure. List of Immediate Cause (Finel disease or condition resulting in death)	•		adeal or as a consequan	Sny ce of):	larche	on desc	9h	On	proximata prval Between set and Death
attending physician and for use as the bunal-transit clan/Medical Examine	Sequentially list conditions, if any, leading to immadiate causa. Entar Underlying Cause (Disease or Injury that Initiated evants resulting in death) Lasf	c		or as a consequent		J				
e attending jed for use as							1			
d by the letached	Part II. Other significant condition  Dulles			sulting in the under	iying cause g	iven in Part I.		Yes No	3 Probabl	cause of death?
page 2 should be Completed by							24a. Was perf	an autopsy ormed?	availab	autopsy findings ble prior to etlon of cause th?
page 2							10	Yes 2 No	1 □ Ye	s 2 No
certificate rector, pag	25. Was case raferred to medical					26. Placa of	Death (Check only			
0 D	examinar? 1 ☐ Yes 2 X No	Hospitel: 1	Inpatient 2	ER/Outpatienf 3	B DOA	thar: 4 🗆 Nursin	g Home 5 X Res	idence 6 □Oth	er (Specify)	
ther the	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investiga		of Injury oth, Day Year)	28b. Tima of Injury	28c. Inju We M 1	ury at ork? ] Yes 2 ☐ No	28d. Describe	how injury occur	red	
To the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 Suicide 6 Could no 4 Homlcide datarmin	ed 288. Plac	a of Injury - At h ling, atc. (Speci	nome, farm, street,	factory, office		28f. Location City or To	(Street end Numb wn, Stete)	per or Rural Ro	oute Number.
he Funera pletely fille edical (	29a. Cartifiar 1 Certifying (Check only one) 2 Medical Ex	caminer: On the b	e best of my kno besis of examina oner stated.	owledge, death occation and/or investi	curred at the t gation, in my	ime, data and pl opinion, death o	ace, and dua to tha occurred at tha time,	causa(s) and ma date and placa,	anner as stated and due to the	d. ceusa(s)
Fo the	29b. Signature and title of certifiar	00	)		29c. Licar	sa number		29d. Data signe	d (Month, Day	, Year)
/	· m	WX.			D.	2504	4	1/181	lev	
50	30. Name and address of person w							,		
	Malik M. Rehma				Ferry	Rd. Bal	timore, M	aryland	21227	
State	31. Date filed (Month, Day, Year)		Registrar's Sign	ature						



Please '

Type or Print in Black Indelible Ink. Assure State of Maryland / Department of Health and	All Copies Are Legible.  Mental Hygiene	10804
Certificate of Death	Reg. No.	
)	2. Data of Daath Month Day Year	3. Tima of De

**Physician** /Medical **Examiner** 

**Funeral** Director

the Maryland ? Is merked other than "natural", or items 23s or 28a-f show traumetic event, the Medical Examiner must be notified at

/Medical Examiner

**Physician** physician and s the burial-transit signed by t To the Hospital or Attanding Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p.

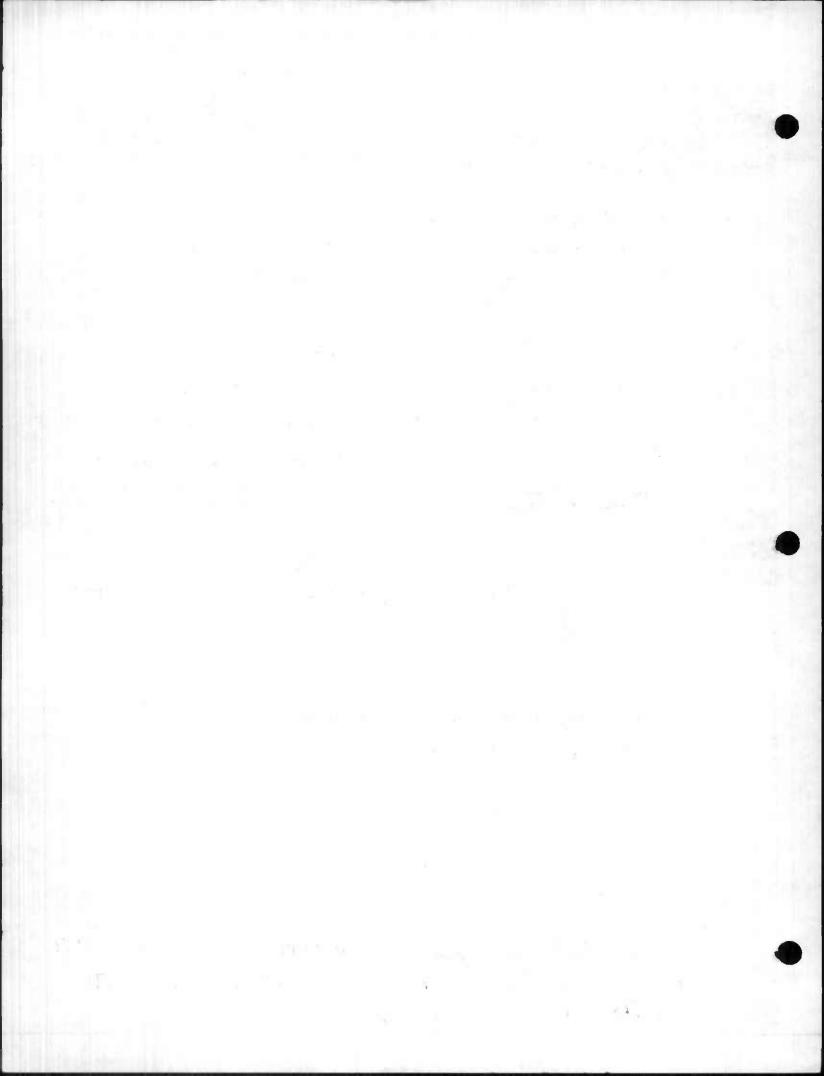
Division of Vital Records, P.O. Box 68760,

1. Decedant's Nama (First, Middla, Lasi Edward W. Parks January 14, 1999 22:45 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville MD Montgomery 7. Aga (In yrs. last birthday) 91 Yrs. If Undar 1 Yaar If Undar 24 Hrs.
Months Days Hours Min. 5. Social Security Number Birthplaca (Stata or Foraign Country) 217-14-1800 1☑M 2□F January 5,1908 Maryland Usual Rasidance of Dacedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yas 2 ☐ No Montgomery Gaithersburg Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 407 Russell Avenue, Apt 512 20877 U.S.A. Funeral Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 12. Was Dacedant Evar In U,S. Armed Forcas? Race - American Indian, Black, White, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: White 1 Yas 2 No Specify: þ 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Loan Officer Banking 17. Fathar's Nama (First, Middia, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Charles C.Parks Margaret E. Smith 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Frances A. Parks (Wife) 407 Russell Avenue, Apt 512, Gaithersburg, MD 20877 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 1/19/99 Woodlawn, MD Lorraine Park Cemetery 22. Nama and Address of Facility
Witzke Funeral Homes, Inc. 21. Signatura of Funaral Sarvice Licensee Lemmer 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Batwe Immadiata Causa (Final a ischemic conditiony a pathy Manam disaasa or condition rasulting in daath) Dua to (or as a consequance of) COLONORY artery disease years Sequantially list conditions, if any, laading to Immadiata ceusa. Entar Undarfying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Physician/Medicai Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown azotemia, hyportension, paroxysmal atrial Completed by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Abrillation, previous colon carchoma, anemia complation of causa of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa rafarrad to medical Be 26. Placa of Death (Check only ona) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 PNatural 5 Panding invastigation 1 Yas 2 No 2 ☐ Accident 6 Couid not be datarminad 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacity) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) January 15, 1999 041794 Priscilla Callahan- Lyon 911 Russell Ave Gaitherslavy, MD

32. Ragistrar's Signatura

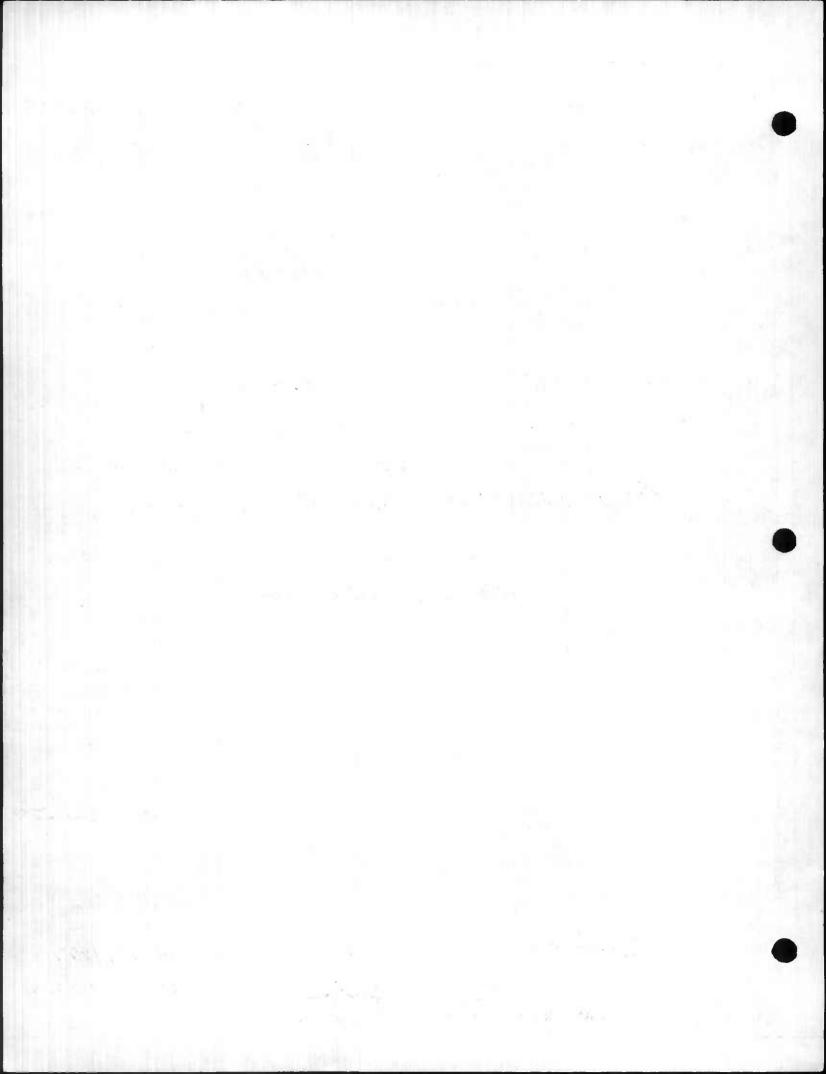
State Registrar



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State of Maryland / Department of Health and Mental Hygiene

I te Physicia		2 Per FH Film G767 1.  1. Decedent's Name (First, Middle, Las		Се	rtificate	of Death	2. Data of Dec	Reg. No.	Year 3.1	Tima of Death
/Medica Examine	al -	Kenneth N. Pattie 4a Facility Nama (If not institution, give	a street and number)			4b. City, Town, or	Januar Location of Death			30 PM
		Countyside Group I	Home			Fulton		Howai	rd	
Funeral Director		213 10 4301	ex 7. Age (	(In yrs. last birthday 90 Yrs.	Months C	ear If Under 24 Hr. ays Hours Mir		h v, Year)	9. Birthplaca ( Country) Maryla	(State or Foreign nd
/and	-	Usual Rasidance of Decedent  10a. State 10b. County	1	10c. City, Town or L	ocation				10d. In	side City Limits
8a-f sh	2	Maryland Howard		Elkridge	9	L.c.l.2			1[	☐ Yes 2月 No
after death with the Marylar or florns 23a or 28a-f show imfres must be notified at		10e. Sireel and Number 6470 Montgomery Ro	oad		101. Zip Co 2107.			10g. Citizen of W USA	/hat Country?	
5 5	by Fur	11. Marital Status  1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 MYas 2 □ No If Yes, Give Year or Dates: 1	11-13-43	Was Deceden If Yes, specify 1□ Yes 20ii	of Hispanic Origin? ( Cuban, Mexican, Pua No Specify:	Specify Yes or No- rto Rican, atc.)	Specify.	Amarican Inc k, White, atc. White	Jian,
1 9	Completed	15. Decedent's Ed (Specify only highest gra- Elemantery/Secondary (0-12)	ucation	16a. Dece (Give	edent's Usual C e kind of work of DO NOT use i	lone during most of we	orking	16b. Kind of Bu		
filed with Hygiene. ther then	0	10th		Elec	ctrical	Technicia	n	BG & E		
Main V	To Be	17. Father's Nema (First, Middla, Last) Ashby Jordan Patt	ie			18. Mother's Ne	ma (First, Middla, Welch	Maidan Sumami	a)	
2 should be and Menta is marked sumatic s	-	19a. Informant's Name/Reletionship (7	ype, Print)	19b. Mail	ing Address (S	treet and Number or F		er, City or Town,	Stata, Zip Code	»)
	_	Margaret Felthouse	e/Niece	6470	Montgo	mery Rd. E	lkridege	MD 210	75	
8 5 2 5		20a. Mathod of Disposition  1   Burial 2 □ Cramation 3 □  4 □ Donation 5 □ Other (Specify			matory or othe	r place)	Data 1/15/00	20c. Location		tete
pemit. Page Department ( Important: If any injury or pnce.		21. Signalura of Funaral Sarvice Licen			2. Nama and A	ddrass of Facility	1/15/99			
80558		Mathlesn W	eber CFS	SP	David J	Weber Fu	neral Hor	mes, P.A.	21229	
Physician		23a. Part1. Entar the disassa, or compshock, or haart failura. List only of	dications that caused the cause on each line.	ne death. Do not en	tar tha mode o	dying, such as cardio	ac or raspiratory ar	rast,	Appr Intan Onse	roximata val Batween et end Deeth
/Medical Examiner	- 1	Immediata Causa (Final disaasa or condition rasulting in daath)	a. SEP	S/S ue to (or as a conse	quence of);				24	hes
nsit .	Examiner		b. INFEC	TED DE	CURISU	S ULCER				
	Ca	Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated events	c	ue to (or as a conse		10.5				
5 0 6	8	resulting in death) Last	d	70 to (01 au a 00150	quorios 01).					
73 6 0	Physician	Part II. Other significant conditions of	intributing to death but	not resulting in the I	underlying caus	a given in Part I.	23b. Did 1	obacco uee con	tribute to the c	cause of death?
E X D	by Phy						10	Yes 2□ No	3 Probably	4 DUnknown
elclen: The law requires that centificate has been signed b irector, page 2 should be determined by	Completed							an autopsy med?	available	utopsy findings e prior to ion of cause ?
The is							101	as 20No	1 ☐ Yas	2□ No
Physician: The this certificate ral director, page	00	25. Was case rafarred to medical axaminar?	Hospital:				ath (Check only o		Cr	سردلا مرد/ب
this ald	0 :	1 ☐ Yas 2 ☑ No 27. Manner of Death	28a. Data of Injury	28b. Time o	1	Injury et	Home 5 ☐ Resid	lence 6 Weths low injury occurr		we that
Hospital or Attending I 24 hours after death. Funeral Director: Atter etely filled in by the funer	Certification:	1 ⊠Natural 5 ☐ Pending invastigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day )	/ear) Injury	М	Work? 1□ Yas 2□ No		Street and Numbi		ita Number
ital or A ins after al Direction		4 Homicida detarmined	building, etc.	(Specify)			City or Tov	m, Stata)		
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifiar 1 Certifying Phy (Check only one) 2 Medical Exam	reician: To the best of r iner: On the basis of a and manner state	xamination and/or in	th occurred at to exestigation, in	na tima, date end place my opinion, deeth occ	e, end due to the curred et tha time,	causa(s) and ma data and place, o	nnar as stated. and dua to tha c	ause(s)
To the comple		29b. Signatura and titla of continu			29c. L	cense number		29d. Data signed	(Month, Day,	Year)
	30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)  TONATHAN FISH MY 3460 EL-ICOTT CTR DA #103 ELLICUTT (IP)  31. Data filed (Month, Day, Year)  32. Recommon Signature								13, 19	99
GX	1	30. Nama and Eddress of person who o	ompleted cause of dea	th (Item 23a) (Type,	Print)	on Him	3 ELLI	CUTT	0 4	2 2 1042
State	e	31. Data filed (Month, Day, Year)	32. Registra	Signature	A	100 2		1,	')	(4) -1 C



Please Type or Print in Black Indelible ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** 6:30 AM RALPH BOYKIN PULLEY 1999 January /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner Anne ARUNDEL Elan Arunda 15 cmmil Orth 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1K) M 2 | F Yrs. 242-24-9411 73 MAY 19, 1925 **Director** NORTH CAROLINA Usual Rasidence of Decedant 10a Steta 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No ANNE ARUNDEL Director MARYLAND GLEN BURNIE 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? must be n Harrie 23s 615 BAYLOR ROAD 21061 U.S.A. Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 XYas 2 No If Yas, Giva 14. Rece - Amaricen Indian, 11. Maritai Stetus Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) the Medical Examiner Black, White, atc. 1 Navar Marriad 2 X Married 8 1 Yas 2 No Specify: Specify: WHITE β 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 1943-46 "natural". 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) NAVAL ACADEMY Dan Coilaga (1-4or 5+) Elemantary/Secondary (0-12) Hygiene. DRIVER U.S. GOVERNMENT 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Mental ahould be marked MARCUS PULLEY ALDONIA MITCHELL -ages 1 and 2 sh, copartment of Health and Is, important if Item 27 is m any injury or oth-20cs. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Coda) MARILYN JEAN DAWSON-PULLEY (WIFE) 615 BAYLOR ROAD, GLEN BURNIE, MARYLAND 21061 Baltimore, 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Data 1 Burial 2 □ Cramation 3 □ Ramoval from State 4 □ Donation 5 □ Othar (Specify) CEDAR HILL CEMETERY 1/20/99 BROOKLYN PARK, MD 22. Nama and Addrass of Fecility 21. Signatura of Funaral Sarvice Licenses SINGLETON FUNERAL HOME, P.A. 1 SECOND AVE. S.W., GLEN BURNIE, MARYLAND 21061 chaul ear 23e. Part1. Enter the disaasa, or complications that out and this death. Do not anter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** Congestive /Medical immediata Causa (Final disaasa or conditior resulting in death) **Examiner** Examiner Coronary con Sequantially list conditions, if any, leading to Immadiate ceuse. Enter Underlying Causa (Disease or Injury that initiated avants resulting in death) Last Due to (or es a consequence of) physician at the bunel law requires that the death certificate be Physician/Medicai Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yss 2 ☐ No signed by p 24b. Wara autopsy tindings evailable prior to 24a. Was an eutopsy Completed completion of cause of death? has 1 Tas certificate Division of Vital Physician: 25. Wes cese referred to medicei axaminar? Be 26. Piaca of Death (Chack only ona) 1 Yas 2 No Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Dey Year) 27. Mennar of Death 28b. Time of 28d. Dascriba how injury occurred 28c. Injury at Work? Certification: After Attanding Naturel 5 Panding after death. 1 ☐ Yes 2 ☐ No invastigetion 2 Accidant 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of injury - At homa, tarm, streat, tactory, office building, atc. (Specify) 4 Homicide ò 24 hours af Funeral Di letely filled is Hospital Scartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner as stated.

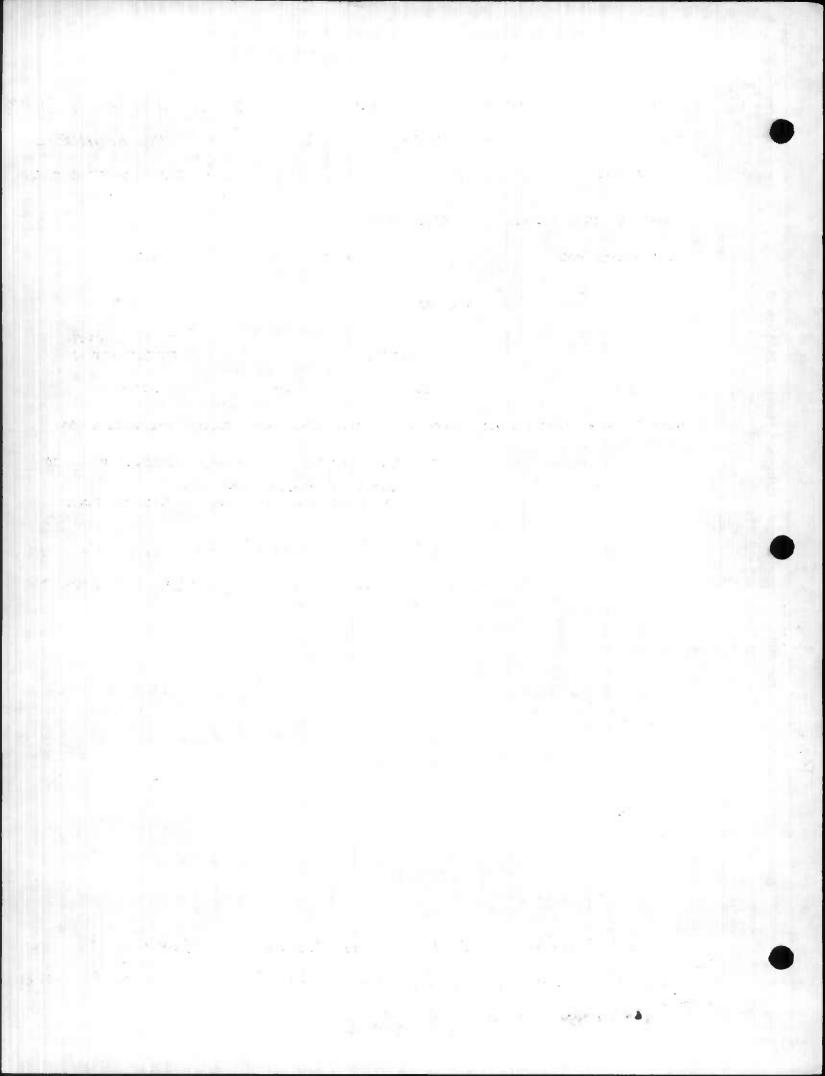
| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, data and plece, and due to the cause(s) and manner stated. edicai 29a, Cartifier within 24 ho To the Fune completely f 29d. Data signed (Month. Day, Year) 29b. Signature and title of certifie 29c. Licansa number 0 January 30. Nama and address of person who completed couse of death (Itam 23a) (Type, Print) (5) an BOAIT 301 KUF T 31. Qate tiled (Month, Dey, Year) 32. Ragistrar's Signatura

**DHMH 16 Rsv 6/95** 

State

Registrar

JAN 1 9 1999



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		. Decedent's Neme (First, Middle	a. Last)		061	tificate o	Dealli	2. Dete of Dee	leg. No.		3. Time of Dec	
ician	ı	MARIE	NGLE				Month 707	Dey	Yeer	20.25		
dical niner							4b. City, Town, or	ity, Town, or Location of Deeth 4c. County of Deeth				
		Church Home Hos	spital				Baltimo	re	n/a			
rai		. Sociel Security Number	6. Sex		s. lest birthday)	If Under 1 Yes Months Day		8. Date of Birth (Month, Dey	Your)	9. Birthpl	ece (Stete or Fo	
OF .	-	18-60-8620	1□M 2 <b>X</b> )F		46 Yrs.	- MOTHER Day	FIQUIS MIN	April 6	1951	Mary		
		Suel Residence of Decedent  0a. State 10b. County		10c (	City, Town or Lo	cation						
5		aryland n/a			altimore						od. Inside City Li 1   Yas 2	
Director	1	0e. Street and Number				10f. Zlp Code			log. Citizen of	What Coun	41	
		31 Wyeth Street				21230						
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Сомріете	-	Elementary/Secondary (0-12)	1	Collega (1-4or 5+)		(Give kind of work done during most of work! life. DO NOT use retired)						
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	2	Signature of Funeral Service L		FC		oln Cre		1/21/99				
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n ai er	d	mmediate Cause (Final issess or condition asulting In death)	Θ	BRAI		MOXIA	4				96 hrs	
ě					(or as e consequ						96 hrs	
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edical	ti	net Initietad events esulting in deeth) Last	C		or es e consequ						J	
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Physician/N	P	ert II. Other significant condition	na contributing to	death but not ra	sulting in the un	darlying cause g	ivan in Part I.	23b. Dld to	bacco use co	ntribute to	the causs of de	
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ошо		5. Wes casa referred to medical					26 Place of Do			10	Yes 2 No	
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Be	2	exeminer?	Hospitel:		28b. Time of			28d. Dascribe ho				
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To Be		exeminer? 1 Yes 2 No 7. Menper of Death 1 Neturel 5 Pending 2 Accident Investigs	28e. Date (Mo	a of Injury onth, Dey Year)	Injury	M 1	Tes ZUNO			28f. Location (Street and Number or Rural Route Number City or Town, State)		
To Be		exeminer? 1   Yes 2   No  7. Menger of Death 1   Neturel 5   Pending	28e. Date (Mo		noma, ferm, stre	M 1[		28f. Location (SI City or Town	treet end Numb n, Stete)	ber or Rural	Route Number,	
To Be	27	exeminer? 1   Yes 2   No  7. Menper of Death 1   Neturel 5   Pending Investige 4   Homicide   Could not determine    9e. Certifier 1   Certifying	28e. Date (Moreover) 28e. Plechad 28e. Plechad 28e. Plechad Phyalclan: To the xaminer: On the	e of Injury - At I ding, etc. (Spec	noma, ferm, stre	et, fectory, office		City or Town	n, Stete) ause(s) and ma	annar as sta	nted.	
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Pollin Shirle 1999 JANUARY 16 12:12AM /Medical 4a Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Y 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 TO F ì, 1932 Washington, Director 578-48-9362 66 Usual Residenca of Deceden the Meryland 10a. Stete 10c. City, Town or Location 10b. Counts 10d. Inside City Limits tem 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic avent, the Mexical Examinal mass be notified at 1 ☐ Yes 2 ♥ No Director Kensington Montgomery MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3905 Dunnel Lane 20895 Funeral USA deeth 12. Wes Deceden! Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yas, Give Yaar or Detes: 11 Marilal Status Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, atc. 72 hours after 1 Never Merried > Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "n any injury or other traumatic avant Elementery/Secondery (0-12) College (1-4or 5+) Her Home Housewife 4+ 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sara Shuster Herman Perlman 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Albert Pollin/Husband 20895 3905 Dunnel Lane, Kensington, MD 20a. Method of Disposition

1 → Buriel 2 □ Cremetion 3 □ Removal from State 20b. Plece of Disposition (Name of cemetary, cremetory or other place) 20c. Location - City or Town, Stele 4 □ Donetion 5 □ Other (Specify) 1/18/99 Judean Memorial Gardens Olney, MD 21. Signeture of Fun rel Service Licens 22. Name end Address of Fecility Ives Pearson Funeral Home 2847 Wilson Blvd., Arlington, 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel 27 days Sepsis disease or condition resulting in daeth) Examiner Dua to (or as a consequence of): Examiner Sequentielly list conditions, if any, leading to immediata cause. Enter Undarlying Cause (Disease or Injury that Initiated avents resulting in death) Last and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the Dua to (or as a consequence of) P.O. Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. the 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 PNo 3 Probably 4 Unknown Records. P 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 ☐ Yes 20 No Division of Vital Be 25. Wes case referred to medical exeminer? 26. Placa of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Certification: To 3□ DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Beath 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? To the Hospital or Attanding F within 24 hours after deeth. To the Funeral Director: After 1 Natural 5 Pending 1 TYes 2 No investigetion 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, larm, street, lectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and menner steled. edicai 29a. Certifie (Check only one) 29b. Signeture end title of certifiar 29c. Licensa number 29d. Date signed (Month, Day, Year) January 16, 30. Name end addrass of person who completed causa of daath (Item 23a) (Type, Print)

State Registrar Alexander Walsh

31. Dete filed (Month, Day, Year)

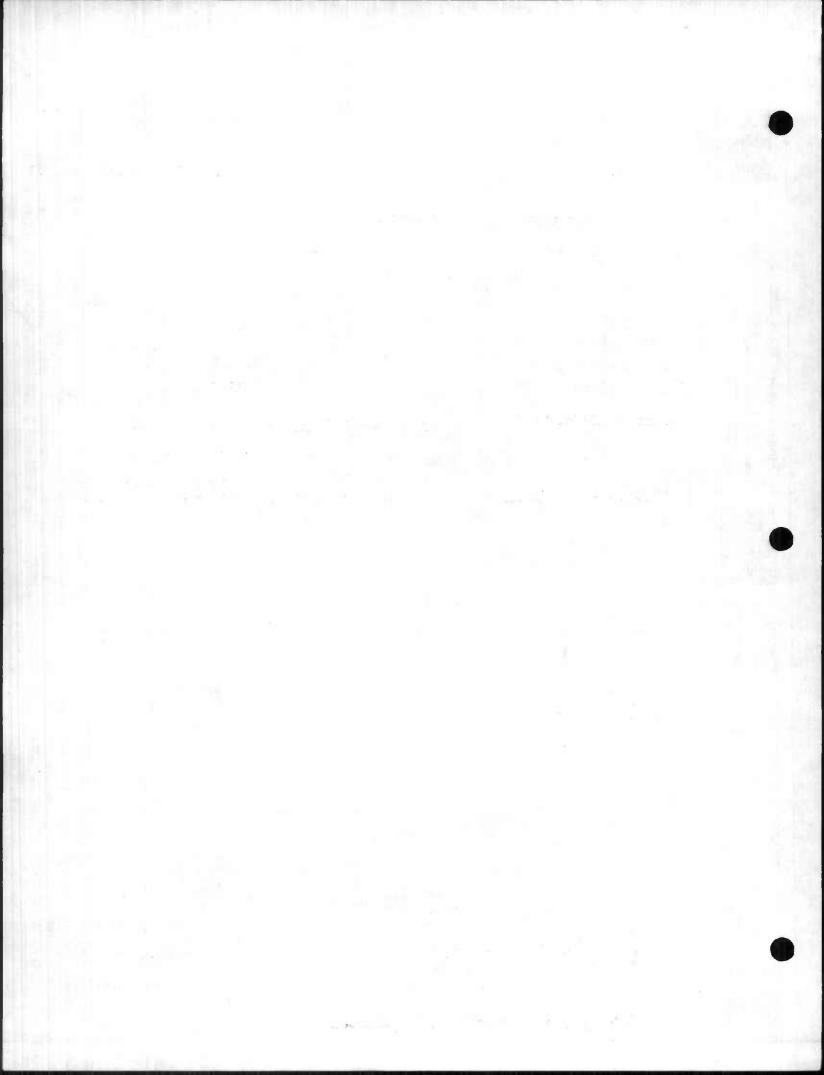
DHMH 16 Rev 6/95

Hospital

Tower 110, John Hopkins

32. Registrer's Signature

600 North Williastreet, Rallimore, Mary but 21205



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death Month Physician RHODA R. POFFENBARGER JANUARY 13, 1999 11:55 P.M. /Medical 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENISES ELDERCARE OF ANNAPOLIS ANNAPOLIS ANNE ARUNDEL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6 Sax Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2♥▼ 91 Yrs. Director 232-10-9754 APRIL 28, 1907 WEST VIRGINIA Usual Residence of Decedent 10n State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or home 23s or 28s-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 ☐ No XX Director ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 55 BREMER DRIVE 21061 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ∑ŽX No If Yes, Give Year or Dates: 11. Meritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien pernit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiens. Important: if item 27 is marked other than "natural", or then any injury or other traumatic avent, the Healthal Energy once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2\\No Specify: Specify: WHITE P 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 PACKER H & M HOSIERY 17. Father's Neme (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumame) THOMAS POLING ALMA WILT 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JERI LAMM - GR. DAUGHTER 55 BREMER DR., GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Deurial 2 Cremation 3 Remova from State 4 ☐ Donation 5 ☐ Other (Specify) MEADOWRIDGE MEMORIAL PK. 1/16 ELKRIDGE, MD 21. Signature of Fundral Service Licenses

KELLY GRAGORY FINE RAYMOND C. FINK FUNERAL HOME OF GLEN BURNIE 26 CRAIN HWY., S.W., GLEN BURNIE, MD and I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, mock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) ayles Bronory Yan Examiner Due to (or as a consequ Examiner physician and the burlei-fransit Sequentially list conditions, if any, leading to immadiate cause. Entar Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? Dely dration 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yes 2 DNo 25. Was casa refarred to medical axaminer? Be 26. Place of Death (Check only ona) Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 DNatural 5 Pending investigation Hospital or Attanding
 Funeral Director: After the funeral Director of the function of the funeral Director of the funeral Di 1 Yes 2 No 2 ☐ Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the To To To the To the I 29b. Signature and title of 29d. Date signed (Month, Dey, Year)

State Registrar

**DHMH 16 Rev 6/95** 

deeth

Baltimore, Maryland 21215-0020

the death certificate be axecuted

Box 68760.

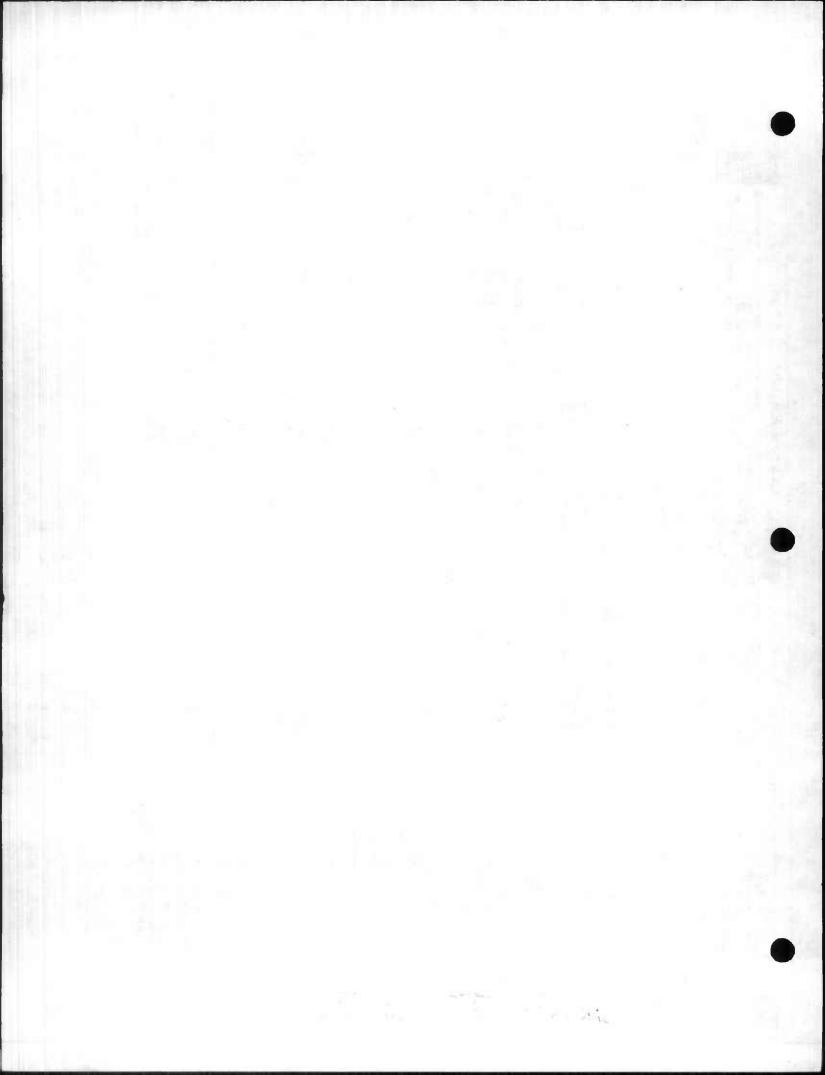
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Records, The lew requires

Division of Vital Attending Physician:

Road #106 odenton MD 21113

lated cause of death (Item 23a) (Type, Print)



### Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible

		Decedent's Name (First, Midd	la, Last)		Cei	rtificate	of	Death	2. Dale				Time of Death
S <sub>i</sub>	Physician /Medical	ANTIONE	ROGERS	mberl				4h City Town	JANC or Location of	ARY		999	320 PM
	Examiner	4e Facility Name (If not institution, give street and number) SHOCK TRAUMA UNIT						BALTIMO				4c. County of Death N/A.	
	ed within 72 hours after death with the Maryland yglene.  Nor than "natural", or items 23e or 28e-f show and the leaders of the month of the completed by Funeral Director	5. Social Security Number 218-76-3635 Usual Residence of Decedent	6. Sex 1 XXX 2 F	7. Age (In yrs. i	last birthday) 22 Yrs.	If Under 1 \ Months D	rear Days	If Under 24 Hours	Airs. 8. Date of (Month	of Birth h, Day, Ye 29	N/I 1976	9. Birthplace Country) NARY	(State or Foreig
		10a. Stata 10b. County		10c. City	y, Town or Lo	cation  IMORE (	CIT	ſΥ				10d.	nside City Limits
			STREET			10f. Zip Co	ode 122	24		10g.	U.S.A	What Country?	
020		3 ☐ Widowed 4 ☐ Divorced	12. Was Dec Armed For 1 Yes	Decedent Ever in U,S. d Forces? es 20No t, Give 1			I of H Cuba	of Hispanic Origin? (Specify Yes or Nuban, Mexican, Puerto Rican, etc.)			A		ndian,
215-0		15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed)	ucation de completed)  College (1-4or 5+)			Decedent's Usual Occupation Give kind of work dona during most of wo life. DO NOT use retired)			rking 16b.		6b. Kind of Business/Industr	
Maryland 21215-0020	T TO A B	17. Father's Nama (First, Middle,	10th grade: unem				18. Mother's Name (First, Middle DEBOKAH VILLIAN						
	s 1 and 2 should be if Hyalth and Mentel them 27 is marked o other traumatic even	19a. Informant's Name/Relations Deborah William	ship (Type, Print)		271	7 Orle	ans	and Number o	Hural Route N	imore	, Mai	ryland	21224
altimore,	It. Page rtment o rtant: If njury or	20a. Method of Disposition  **MRUrial 2 Cremation 4 Donation 5 Other (S  21. Signature Funeral Service	Specify)	State	ometery, cree NG MEM	sition (Name natory or othe ORIAL 1	PAI	RK	1-20			ORE, MA	
ä	Depa Impo	Darbara	A.R.	non	1	1206	W.	MORTH	WN COMM			ERAL HO	ME PA
	Physician /Medical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)		Due to (or						ory arrest,		inta	proximata Irval Batween set and Death
o î	e be axecuted side and e burlet-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	<b>6</b>	Due to (or	r as a consec	juence of):				-			
-	e physical	that initiated events	c	Due to (or	ras a conseq	uence of):						0	4.30
Ö	d by th	Part II. Other significant condition	ons contributing to de	eath but not resu	ulting in the u	nderlying caus	se giv	ven in Part I.	23b.	Did tobe	cco use co		cause of death
-	een signe hould be o				8	ĵej.				Was an a performed		availat	autopsy tindings de prior to ation of cause h?
ecords	has been a 2 shound mplete							D6 DI	Darate (Charles	t∰ Yas	2 No	184	s 2 No
Records	The lay		4										
Records	The lay	25. Was case referred to medica examiner?	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA	Oth	26. Placa of her: 4 ☐ Nursir			e 6 🗆 Ott	ner (Specify)	
of Vital Records	clan: The lay entiticate has ector, page 2 Be Comp	25. Was case referred to medica examiner?	Hospital: 1 1 26a. Data (Monigation /-/5	of Injury th, Day Year)	ER/Outpatier 28b. Time of Injury 223/	-	Injur Wor	er: 4□ Nursir	g Home 5□ 28d. Desc SU	Residence ribe how i	shot		

31. Date filed (Month, Day, Year) 32 , IAN 1 9 1000 32. Registra Signatura

29b. Signature and title of certified

O.C.M.E.

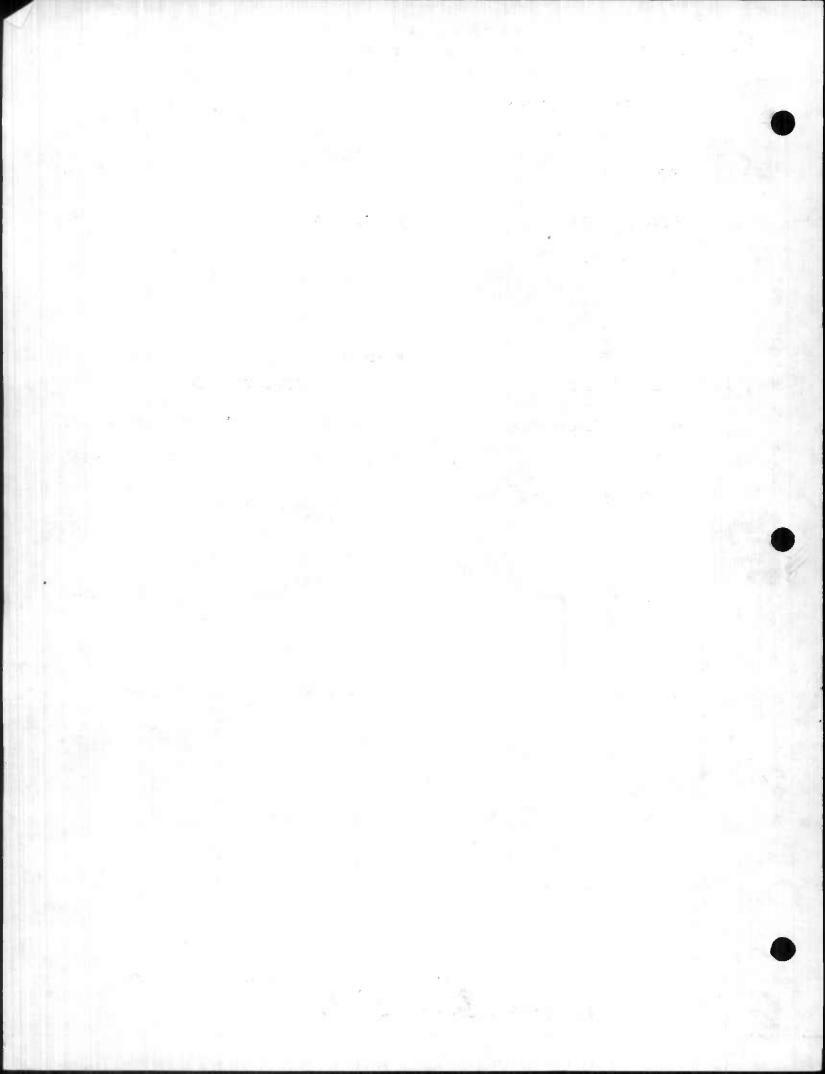
29c. License number

29d. Date signed (Month, Day, Year) JANUARY 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Yeer 4e. Facility Neme (If not Institution, give street end number) 2:00 PM January 16 1999 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Last birthdey)

| If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Months | Deys | Hours | Min. | Months | Min. | Months | Min. | Months | Min. | Months | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. 4050-191 Baltimere 8. Dele of Birth (Month, Day, Year)
MAY 6, 1918

9. Birthplace (State or Foreign Maryland 6. Sex 5. Social Security Number 7. Age (In yrs. last birthdey) 10 M 20 F **Funeral** Director 226-14-0891 Usuei Residence of Decedent the Menyland permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiene.

Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show enty injury or other traumatic event, the Medical Exacting rount be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 No Director MD Ball mone Rangallyteun 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 21133 Funeral Robusson RO 4511 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Yes 2 Alo If Yes, Give Yeer or Detes: 14 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pharmaceutical Elementery/Secondery (0-12) College (1-4or 5+) Sales Clerk Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Thomas Ray Lillian McNew 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1355 Woodland Dr. Westminster, MD 21157 of Disposition (Neme of Date 20c. Location - City or Town, Stete Thelma V. Ray/sister 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 1 Burial 2 Termetion 3 Removel from Stete Metro Crematory, Inc. 01/18/99 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 21. Signeture of Funerel Service Licensin Cremation Society of Maryland, Inc. Edward Cresorchik 299 Frederick Rd. Baltimore, MD 21228 Approximete Intervel 5 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Finel disease or condition resulting in death) · Concur OF The Examiner Due to (or es a consequence of): Examiner signed by the ettending proved and detached for use as the bone transit Sequentielly ilst conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of). Box 68760 Physician/Medical Due to (or es e consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown abstruct.ux Luni DITTE by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? peen has 2 No certificate 1 Yes 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the luneral director, 8 25. Wes case referred to medical axeminer? 28. Place of Deeth (Check only one) Hospitel: 2 ER/Outpatient 3 DOA 1 Yes 20 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. Dete of Injury (Month, Dey Year) Certification: 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Neturel 1 ☐ Yes 2 ☐ No investigetion 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of fnjury - At home, ferm, street, fectory, office bullding, etc. (Specify) 4 Homicide 12 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted.
2 Medical Examinar: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end menner steted. edical 29e. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Olcef leec 122085 Tonuary 16, 1999 30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

OID COURT

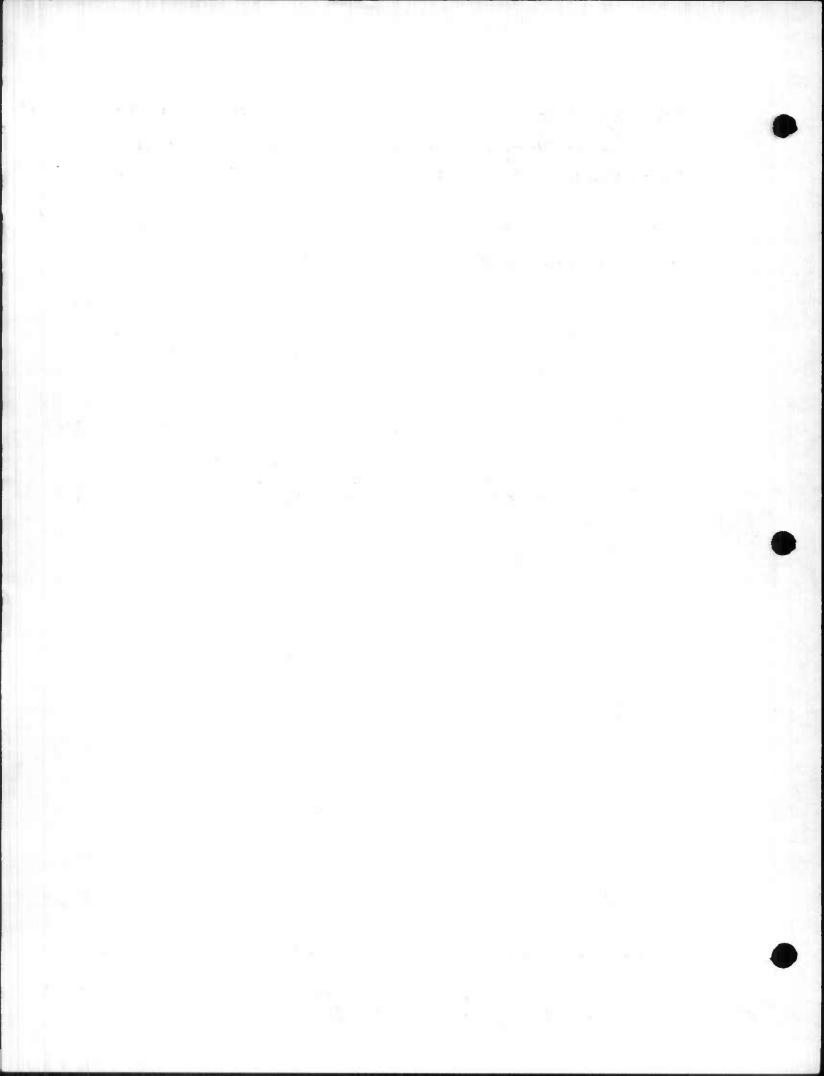
RP. 21153

Dey, Year)
JAN 19:293
Signeture

J-

31. Dete filed (Month, Dey, Year)

State Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month January 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death GIEM BUTTIE IT N'I'VE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Days Hours Min. Min. April 22,1922 4c. County of Deeth Glen Burnie Anne Arunde 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 1 M 2 □ F 215 12 0531 Yrs 76 Maryland Usual Rasidence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 No Anne Arundel Maryland Pasadena 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? 7921 Tick Neck Road 21122 U.S. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Biack, White, efc. 1X Yes 2 □ No If Yes, Give Yeer or Detes: W • W • II 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiemantary/Secondery (0-12) College (1-4or 5+) Welder Welding 8th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Henry Real Frances L. Younger 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stete, Zip Code) Katherine Real wife 7921 Tick Neck Road Pasadena, Maryland 21122 20b. Pleca of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removal from State 1/18/99 Baltimore, Maryland 4 □ Donetion 5 □ Other (Specify) Cedar Hill Cemetery 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltim or or mylications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, the one cause on each line. Baltimore, Md. 21225 Approximate Onset and Deeth SEIPSIS Immediate Cause (Finel disease or condition resulting in deeth) Dua to (or es e consequenca of): VICERS DECUBITAL RYERY DISEASE Due to (or es a consequence of) PEIZTENSION 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were eutopsy findings evailable prior fo 24e. Wes en eutopsy performed? completion of cause of daeth? HYPERLIPIDEMIA 2 9 No 1 Yes 2 No 25. Wes casa rafarred to medical exeminer?

**Physician** /Medical **Examiner** 

2

signed b

funeral

à

Physician/Medical Examiner

Completed by

Be

Certification: To

Medical

**Physician** 

/Medical

**Examiner** 

Funeral

Director

28a-f show notified at

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Herns 23a

"naturel", or

Peges 1 and 2 should be filed within 7 nent of Health and Mentel Hygiene. nt: If Item 27 Is marked other than "r

item 27 le

Depertment of Important: If It any Injury or o

Examiner must be

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Director

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the Marylend

72 hours efter

Baltimore, Maryland 21215-0020

Box 68760

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Records.

Division of Vital

Hospital or Attending

To the

death.

after death Director:

within 24 hours a

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest

1 Yes 2 No

5 Pending

invastigation

6 Could not be

27. Manner of Death

1 Maturel

2 Accident

3 Suicide

29e. Certifier

4 Homicide

Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

28a. Date of Injury (Month, Day Year)

TRACHEOSTOMY ASPIRATIONS

Hospitel: 1 ☐ Inpafienf 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Piace of Injury - At home, farm, streat, factory, offica building, etc. (Specify)

28b Time of

26. Piece of Deeth (Check only one)

28c. Injury et Work?

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how Injury occurred 1 Yes 2 No

28f. Location (Streat end Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of carrier

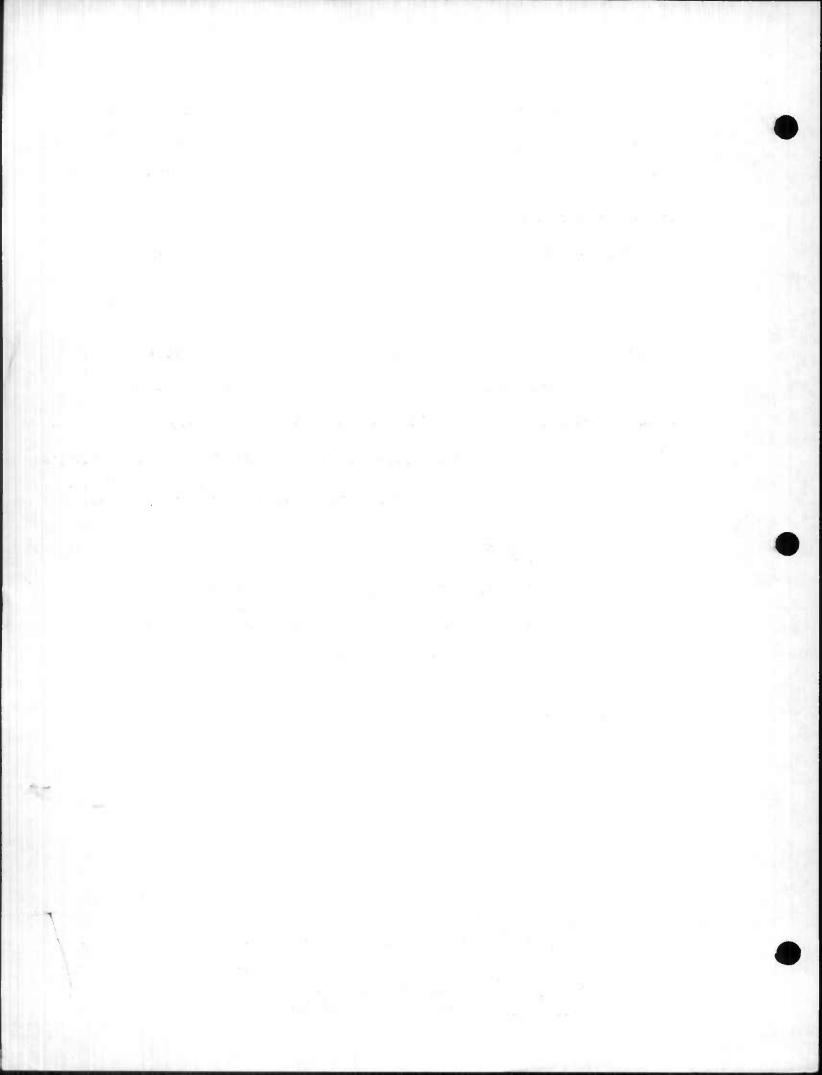
29c. License number

29d. Dete signed (Month, Dey, Year)

30. Name and eddress of person who completed cause of deeth m 23e) (Type, Print)

5 31. Date filed (Month, Dey, Year) 32. Registra Crain Towers, GLEN BURIE

Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

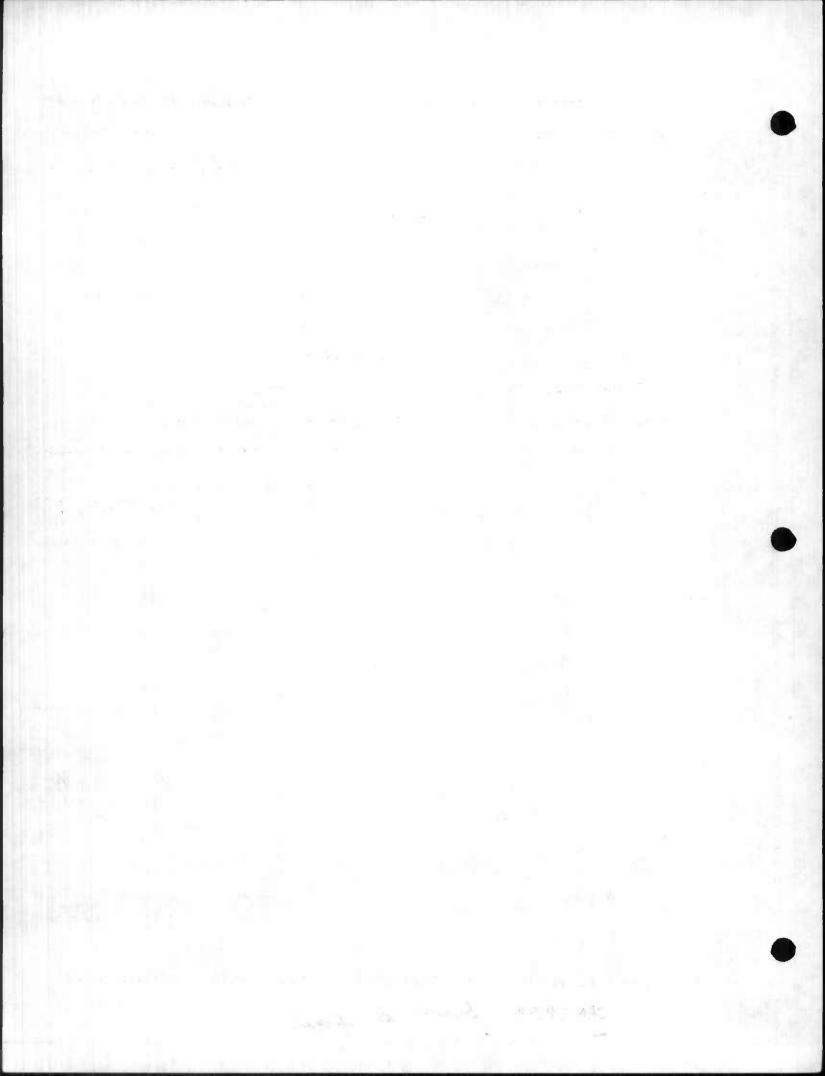
State of Maryland / Department of Health and Mental Hygiene

00813

			Certificate of	Death	Reg. No.					
Physician /Medical	Decedent's Nama (First, Middle, Last)     Dorothy				2. Dete of Death					
Examiner	4a Facility Name (If not institution, give s Saint Joseph M			4b. City, Town, or L	on Baltimore					
Funeral Director	102 00 2210	7. Aga (In yrs. last b	oirthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jun 12	Year) 1912	Birthplace (State or Foreign Country) Tennessee			
th the Maryland or 28e-f show a notified at Mrector	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A		wn or Location				10d. Inside City Limits 1 → Yes 2 → No			
5 _A W			10f. Zip Code 21211		10	0g. Citizen of Wh				
uid be filed within 72 hours after death with the Marylar Mental Hygiens.  Mental Hygiens.  Medical Examiner must be notified at the event, the Medical Examiner must be notified at To Be Completed by Funeral Director.	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yea, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black,	American Indian, White, etc. White			
thin 72 ho to. Medical a	15. Decedent's Educity only highest grade  Elementery/Secondery (0-12)		a. Decedent's Usuel Occup (Give kind of work done life. DO NOT use retire	during most of work	ing	16b. Kind of Busin				
d 2 should be liled within 72 hours all mand Mental Hygiens all marked other than "natural", or treumetic event, the Medical Exam To Be Completed by F	unk 17. Father's Name (First, Middle, Last) William Brock		Home Mak	18. Mother's Nam		Own Ho				
off and 2 sho off and 27 is my	19a. Informent's Name/Relationship (Tyr Arnold Stagnoli		9b. Meiling Address (Street	Bertha Davis						
permit. Pages 1 as Department of Hea reportant: if Nem. my injury or othe Mice.	20a. Method of Disposition  1  Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)	20b Place	of Disposition (Name of tery, cremetory or other pla Haven Mem Pa	ce)	Date 2	20c. Location - Ci	ty or Town, State rnie, Marylan			
permit. Departm Imports any inju	21. Signeture of Funerel Service License	leik. U	22. Name and Addre A. Alan Se	eitz, Jr.			ryland 21211			
Physician /Medical Examiner	23a. Pert1. Enter the disease, or complishock, or heert feilure. List only on Immediate Cause (Final disease or condition resulting in death)	PNEUMONIA	o not enter the mode of dyi a consequence of):	ng, such es cardiac	or respiratory arre	est,	* Approximate Interval Between Onset and Death 7 DAYS			
ires that the death certificate be executed signed by the attending physician and die detached for use as the burial-transit by Physician/Medical Examiner	Sequantielly list conditions, if any, leading to immadiete cause. Enter Underlying Cause (Disease or injury thet initiated evants resulting in deeth) Last		e consequence of):			V.				
requires that the death certine sensitive bould be detached for use a seted by Physician/M	Part It. Other significant conditions con	Inbuting to death but not resulting	In the underlying cause gi	ven in Pert I.		_	ibute to the cause of death			
The law requires cate has been sig page 2 should b					24a. Wes er perform		24b. Were autopsy tindings available prior to completion of cause of death?			
ysician: The law requires t is certificate has been signe director, page 2 should be.	25. Was case reterred to medical			26. Place of Deal	1 ☐ Ye	/	1 ☐ Yes 2 No			
Physician: rhis certific ral director.	examiner?	ospital:	Outpatient 3 DOA	ner: 4 Nursing Ho	ome 5 Reside	nce 6 Other	(Specify)			
To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	27. Menner of Death  1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Dete of Injury (Month, Day Year) 28b.	. Time of language 1 28c. Injury Wo	ry at rk?  Yes 2 ☐ No	28d. Describe ho					
ospital or Attending Physician: Thours after death.  Thours after death.  It is not the funeral director, py filled in by the funeral director, py cal Certification: To Be C.	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)			City or Town	n, Stete)	or Rural Route Number,			
To the Hospital within 24 hours To the Funeral completely filled	29e. Certifier (Check only one)  2 Medical Examin	Ician: To the best of my knowledger: On the basis of examinetion a and manner stated.	ge, deeth occurred at the ti- and/or investigation, in my o	me, date end place, opinion, deeth occur	end due to the ca red at the time, da	ause(s) and mannate and piece, an	ner es stated. d due to the cause(s)			
To the Howithin 24 To the Fucomplete	29b. Signeture and title of certifier	ista, mo	29c. Licens D 4 1 4		Jane	9d. Date signed (	Month, Day, Year) Ith 1999.			
10	30. Name and address of person who con JOGINDER P. MEH			RIVE, TO	OWSON,	MARYLA	ND 21204			
State Registrar	31. Data filed (Month, Day, Year) JAN 19	32. Registratis Signature	B. 10							

DHMH 16 Rev 6/95

Reynolds, Dorothy Luverna



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth Martha Rerko Monthanuary 12, 1999 ear 4b. City, Town, or Location of Death 4c. County of Death Columbia **Lorien Nursing Home**

1. Decedent's Name (First, Middle, Last) 7:15 AM **Physician** /Medical 4a Fecility Neme (If not Institution, give street end number) Examiner Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 82 vre If Under 24 Hrs. Dete of Birth (Month, Day, Year) April 13, 1916 If Under 1 Year 5. Social Security Number **Funeral** Days Months Hours 172-18-2389 1 M 2 F Pennsylvania Director Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or flema 23a or 28a-f show treumstic event, the Medical Examiner must be notified at Maryland Howard 1 Yes 2 No Columbia Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 21044 U.S.A. 6334 Cedar Lane death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or iten any injury or other treumetic event, the Medical Example 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1□ Yes 2×No White Baltimore, Maryland 21215-0020 Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Home Elementary/Secondary (0-12) College (1-4or 5+) Housewife 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Charles Karalfa Mary Luther 2 19a. informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 6410 Hanover Crossing Way Hanover, Maryland 21076 Ms. Cynthia M. Pavlosky Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 01/15/99 Metro Crematory Baltimore, Maryland 5 ☐ Other (Specify) San ature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. M00535 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner ascular Accident Examiner that the deeth certificate be executed bunial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last end brillation P.O. Box 68760. physician Physician/Medical the Due to (or as a consequence of): 88 ensio signed by the et id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 2 No 3 Probably 4 Unknown epression Division of Vital Records, p 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Completed peen : has 1 ☐ Yes 2 No 1 Yes this certificate or Attending Physician: after death. Director: After this certifica 25. Was cese referred to medical director, Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Tes 2 🗆 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 24 hours a Funeral D Leave the control of the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examineion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 To the

State

31. Date filed Month, Day, Year) JAN 191999

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Marquerite



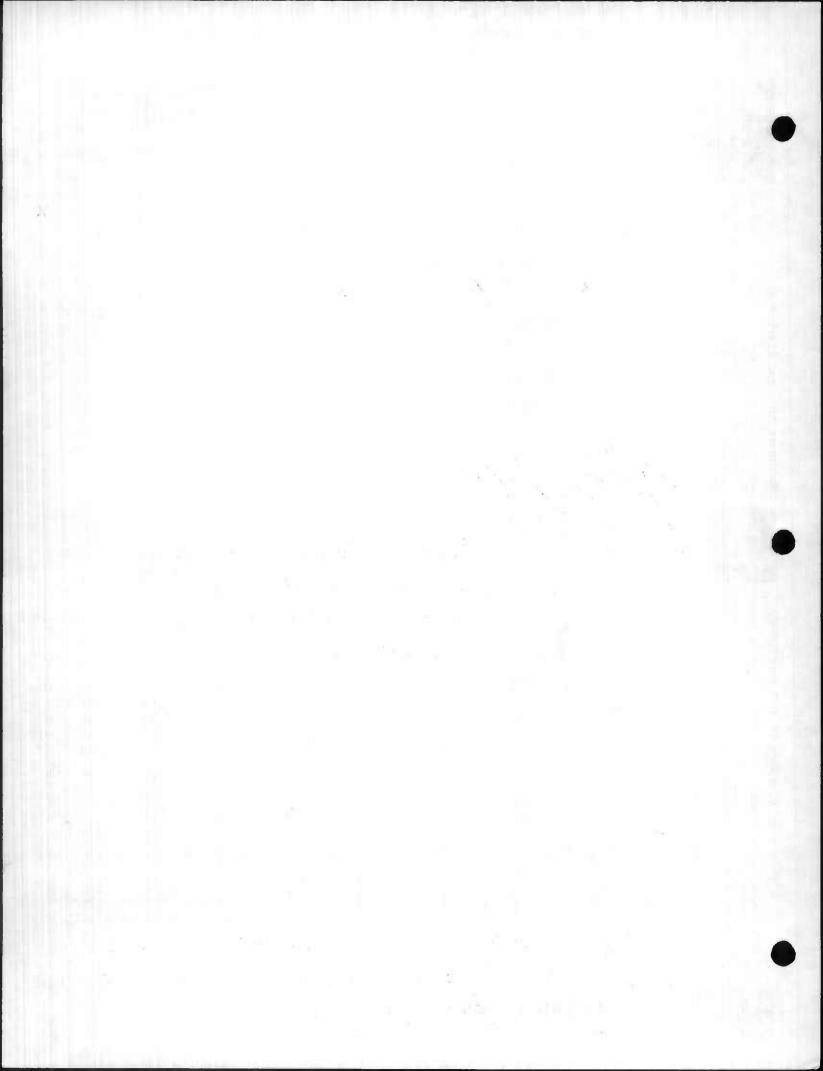
29c. License number

29d, Date signed (Month, Dev. Year)

Colombia UD 21045

Registrar

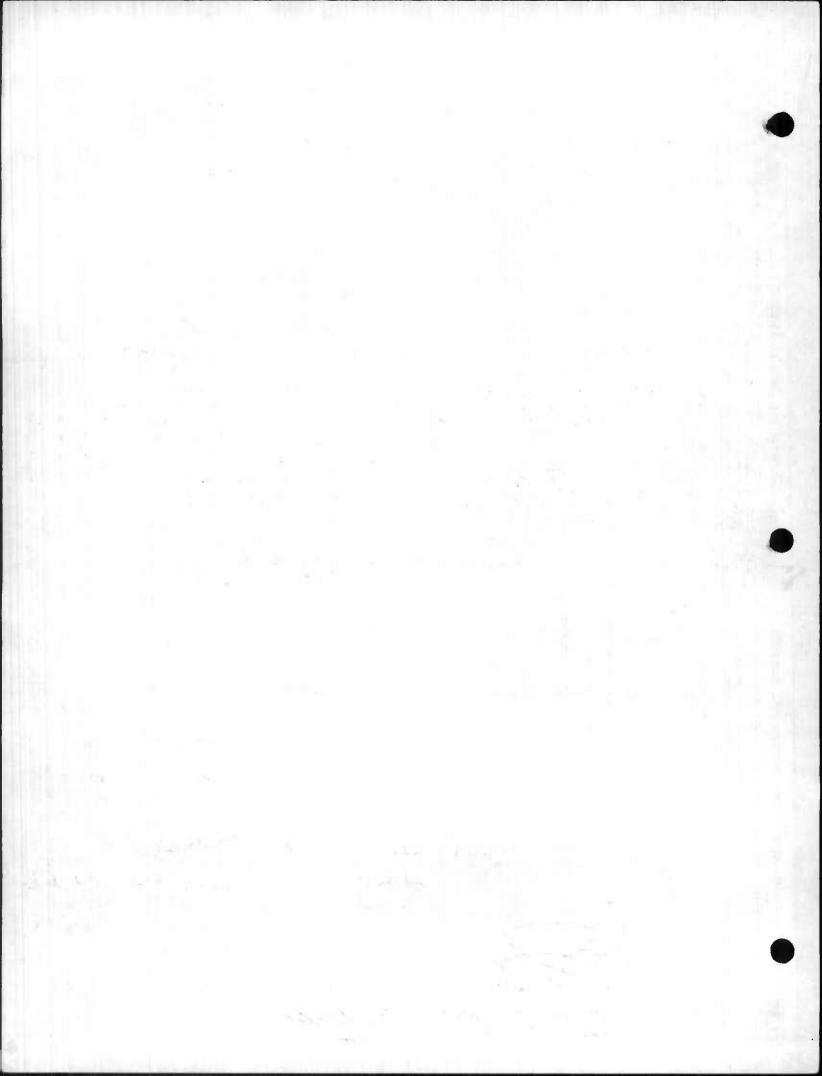
**DHMH 16 Rev 6/95** 



State Registrar filed (Month, Day, Year) 32. Registra's Signature JAN 19199

111 Penn Street, Baltimore, Maryland 21201

B. Sports



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 7 per F.H G-767 1/20/99 reb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tims of Death 6:00 AM JANUARY Eugene Smith 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 9 Stella Maris Hospice Mercy Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours Months 1 M 2 F 89 Yrs. 241-48-7956 64 06-03-34 SC Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Yes 2□ No NA Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1541 N. Patterson Park Ave. 21213 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Towson State Univ. Maintenance llth Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Smith Etolia Caldwell Leon 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 Smith 1541 N. Patterson Park Avenue Balto., MD. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem.Pk. Cem. 01-21-99 Arbutus, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue moun mand 23a. Part1. Enter the disease, or compricetions that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of):

**Physician** /Medical Examiner

portant: If Item 27

ъ

**Physician** 

/Medical

Examiner

MD

Director

Funeral

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Be Completed

**Funeral** 

Director

28a-f

"natural", or items 23s or

filed within 72 hours after

Pages 1 and 2 should be

altimore, Maryland 21215-0020

UGENE

Examiner physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical signed by the attending p should Medical Certification: To this After death. 24 hours after deat Funeral Director:

Part II. Other significant conditions o	ontributing to death but not re	23b. Did tobecco use co 1 ☐ Yes 2 No	23b. Did tobacco uss contributs to the cause of death?  1 Yea 2 No 3 Probably 4 Unknown					
	145			24a. Was an autopsy performed?	24b. Were sutopsy findings available prior to completion of cause of death?			
25. Was case referred to medicel			26. Place of D	eeth (Check only one) STELL	LA MARIS ATMER			
1 Yes 2 No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 Oth	ner (Specify) HOSPICE			
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. tnjury at Work? 1 Yes 2 No	28d. Describe how Injury occur				
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, ferm, street, fec	28f. Location (Street end Numb City or Town, State)	28f. Location (Street and Number or Rural Route Number, City or Town, State)				

29c. License number

Bultmen Md

29d. Date signed (Month, Dey, Year)

21202

141

State Registrar

filled in by

29b. Signature and title of certifie

30. Name and address of preson w

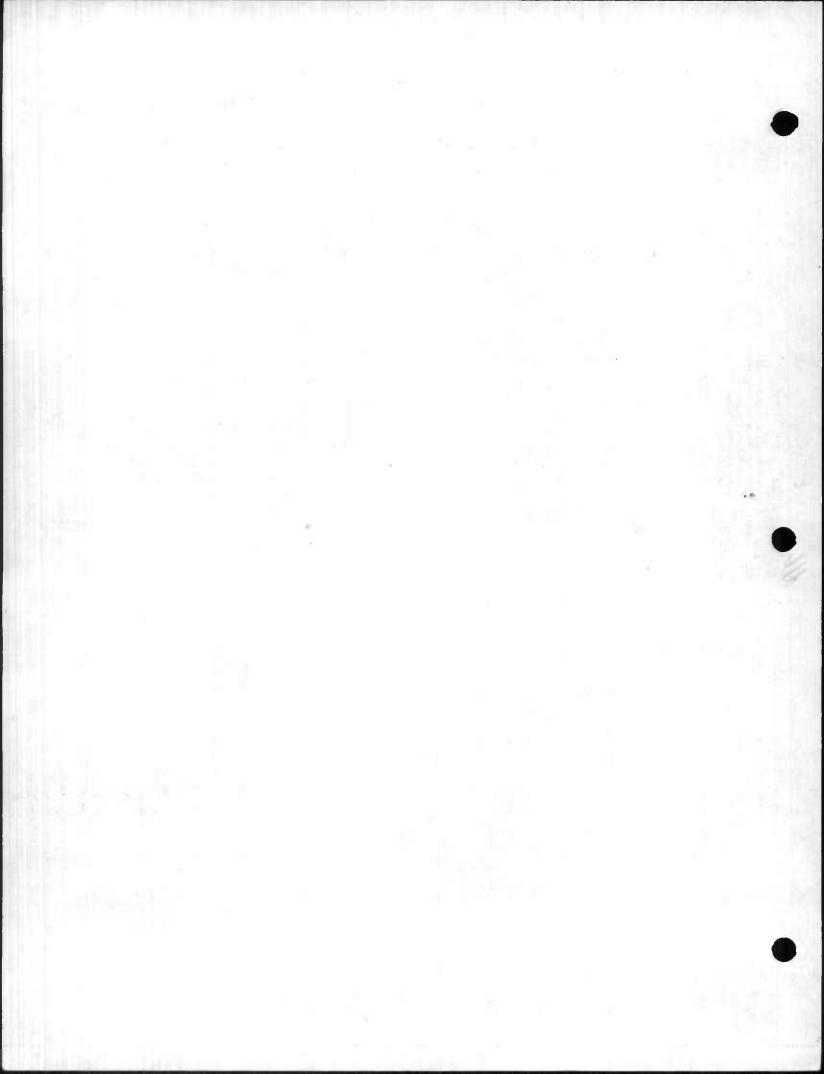
31. Date filed (Mor

Hospital

\$

within 2

no completed cause of death (Item 23a) (Type, Print) M 32. R. histrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day LOUISE DASCENZO SCHAFER TANUARY 1999 16. 5:15 AM 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Saint Joseph Medical Center Towson Baltimore If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 8. Dete of Birth (Month, Day, Ye Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours Months 1 M 2 KF 214-03-5294 83 March 16, Yonkers, New York Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Co. Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 17 Treeway Court Apt. 38 21286 United States of America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yas 2 🗓 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Probation Dept. Elementery/Secondary (0-12) College (1-4or 5+) Administrator State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Domenic D'Ascenzo Filomena Maria Tiraboschi 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Rosalyn D'Adamo (Daughter) 10206 N.E. 68th Street Unit C 102 Kirkland, Washington 98033 20b. Place of Disposition (Name of 20a. Method ol Disposition 20c. Location - City or Town, State cemetery, cremetory or other place) 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Ramoval Irom Stete Parkwood Cemetery 01/20/99 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Jeffrey L. Gair 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part. Errier the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Ceuse (Finel BONE MARROW FAILURE disease or condition resulting in deeth) Due to (or es a consequence of) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown MULTIPLE MYELOMA 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was en eutopsy performed? 2 X No 22 No 1 ☐ Yes 1 Yes 25. Was case refarred to medical axaminer? 26. Place of Deeth (Check only one) 1 Yes ≥ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of tnjury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, larm, street, lectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier

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**Funeral** 

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29b. Signatura and title of certifier

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**DHMH 16 Rev 6/95** 

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29c. License number

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29d. Date signed (Month, Day, Year)

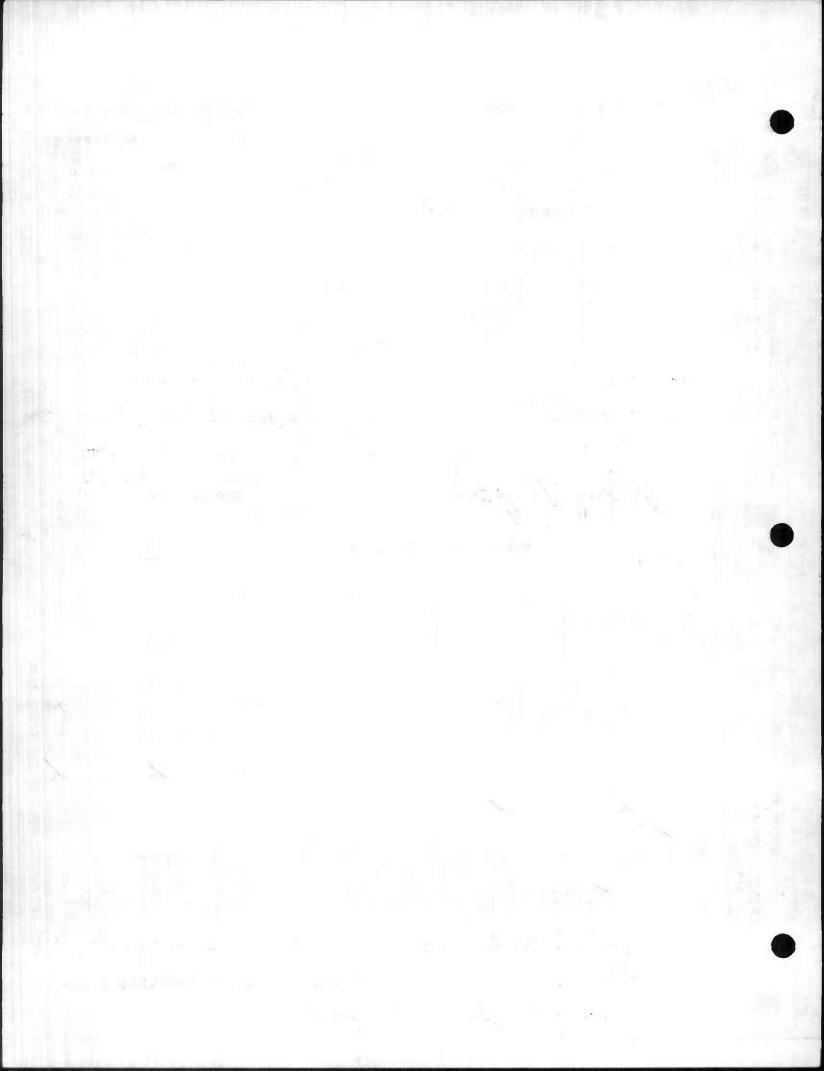
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Physician/Medical à Completed Be 70 Certification:

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Division of Vital Records.

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings evallable prior to complation of cause of death? 24a. Was en autopsy performed? Y Yes 2 No 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 NResidence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Injury Found: 1 Netural 5 Pending Found: 1 Yes 2 No UNKNOWN investigation 2 Accident 1-12-99 6:00 6∑ Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 5654 KAVON AVE. 4 I Homicide FOUND: RESIDENCE BALTIMORE, MARYLAND 29a. Certifie 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) and menner steted. (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signatura and title of certifier JANUARY 12, 1999 OCME

Registrar

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31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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**Physician** /Medicai **Examiner** 

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OBESITY BILATERAL TOTAL KNEE REPLACEMENT 25. Was case referred to medical examiner? Other: 4 Nursing Homa 5 Residenca 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 26a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Sulcida 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 👺 certifying Physician: To the best of my knowledge, death occurred at the time, date and piaca, and due to the cause(s) and manner es stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

State Registrar

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29c. License number

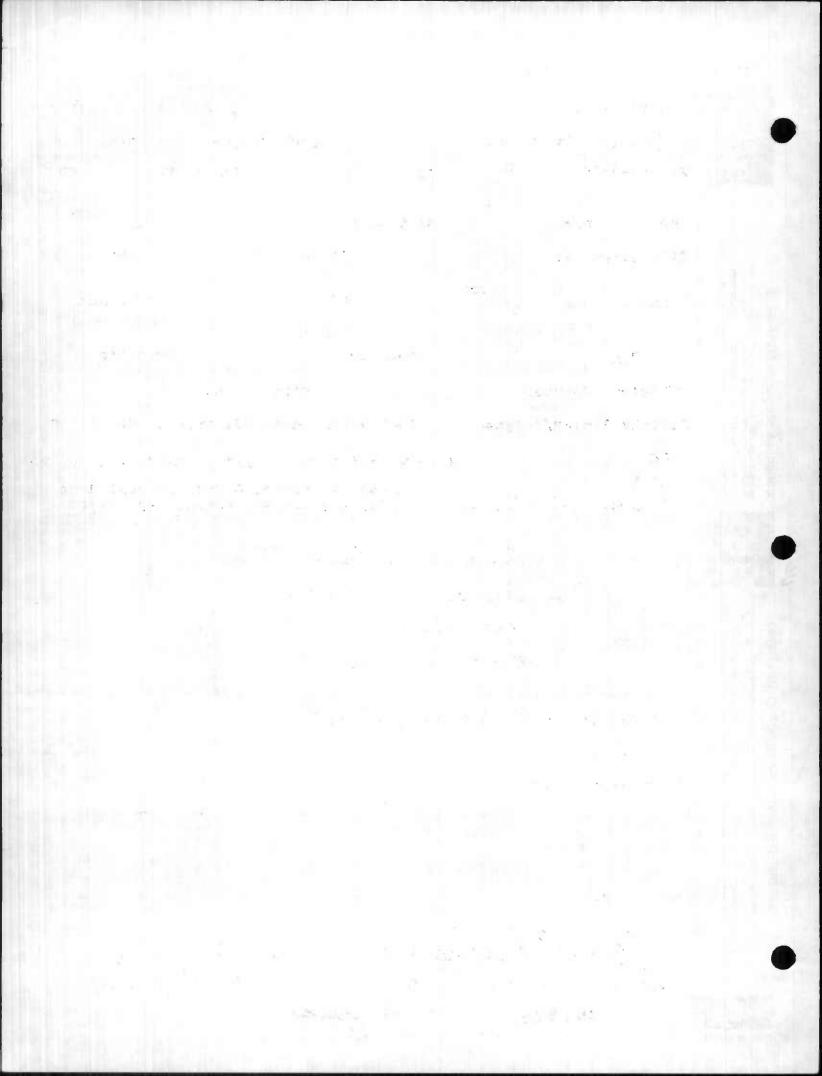
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29d. Date signed (Month, Day, Year)

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**DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene \( \text{\text{\$\text{\$}}} \) Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Month Stone Marian 9:37 PM January 1999 /Medical 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore
If Under 1 Yaar | If Under 24 Hrs. 8. D.
Months Days Hours Min. (A n/a5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplaca (Stata or Foreign Country) **Funerai** Days 1 M 2XX Yrs Director 216-36-0358 58 Aug. 15 1940 Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. inside City Limits 28a-f show the Medical Examiner must be notified at Md. Baltimore Middle River Director 1 Yes 2 No 10f. Zip Code 10e. Street and Numbar 10g. Citizan of What Country? 6 305F Retford Way 21220 USA Herna 23a Funeral death 11. Marital Status 12. Was Decedent Ever in U,S Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. should be filed within 72 hours efter nd Mentel Hygiene.

marked other than "natural", or ite 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: 1 Yas 2 No Specify: Specify: by White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grade complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Church Hospital Clerk 12th 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pages 1 and 2 should be finent of Health end Mentel I inter 27 is marked of Robert Clark MArian Blanche Wilker 19a. Informent's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health or Important: If Nem 27 is any Injury or other trau John Newby / son 7319 Cedar Ave. Jessup Md. 20794 20a. Method of Disposition 20b. Piace of Disposition (Neme of 20c. Location - City or Town, State cemetery, crematory or other plece)
Metro Crematory Inc. 1 ☐ Burial 2 ☐ Crametion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 1/19/99 Baltimore Md. 21. Signature of Funeral Sarvice Licens 22. Name and Addrass of Facility Connelly Funeral Home of Essex nter the disease, or of mplications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, a heart failure. List only one cause on each line. Approximate Onset and Deeth **Physician** /Medical Immediata Cause (Final Septic Shock disease or condition resulting in death) Examiner Due to (or as e consequenca of) Examiner Pulmonary Hypertension physician and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cardiogenic Shock Physician/Medical Due to (or as a consequenca of): use as Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown DIC þ 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? Acidocis page 2 1 ☐ Yes 2 18 No 1 ☐ Yas 2 ☐ No Be 25. Was case referred to medical 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 Stripatient 2 ☐ ER/Outpatient 3 ☐ DOA Bills 28a. Data of Injury (Month, Dey Yeer) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After Attending 5 Pending investigation 1 Natural death. 1 Yes 2 No after death Director: 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Straat end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 8 within 24 hours of To the Funeral Completely filled Hospital 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as steted.

2 Madical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 4 29b. Signature and title of certifier 29d. Dala signad (Month, Day, Yeer) 29c. License number Intern P12558 January 17, 1999 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Good Samaritan Hospital 5601 Loch Rayon Blvd Donabedian Maral Baltimore, MD 21239

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Dey, Year)

JAN 1 9 1999

32. Registrar's Signature

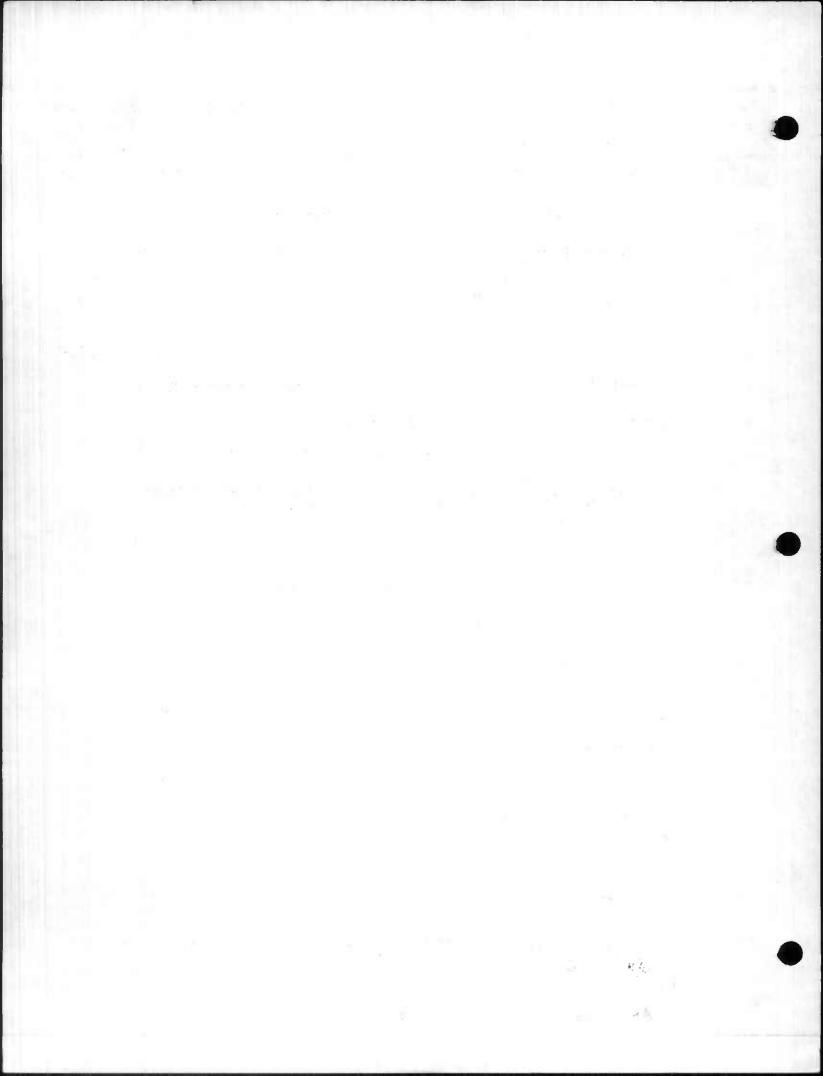
Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records.

Division of Vital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 6:30 Pm Month Physician Jaman Donald Μ. Shaskey /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Deeth Examiner N/A
If Undar 24 Hrs. 8. Dete of Birth
(Month, Dey, Year) North Arundel Hospital Anne Arundel

9 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 1 M M 2 □ F Months Days Yrs. Nov. 1,1930 Director Maryland 217-26-5991 Usuel Residence of Decedent 68 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r 25a-t show notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number b traumetic event, the Medical Examiner must be 'natural', or flams 23s. U.S.A. Funeral 21122

13. Wes Decedent of Hispanic Origin? (Specity Yes or NoIt Yes, specify Cuben, Mexican, Puerto Rican, etc.) 8201 Bodkin Ave 12. Was Decedent Ever in U,S. Armed Forces?
1 题 Yes 2 □ No 1951—1953 14 Beca - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedent's Education (Specify only highast greda completed) d Mental Hygiene. marked other than Etementary/Secondery (0-12) Cotlege (1-4or 5+) 8 Production Coordinator Westinghouse Company 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be 2 should be f and Mental 9 Alexander Youskauskas Thelma Whitlock 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) permit. Pages 1 and 2 al Department of Health and Important: If Item 27 is n ä Lorraine Shaskey (Wife) 8201 Bodkin Ave Pasadena, Maryland 21122 20b. Ptece of Disposition (Neme of cematary, crametory or other placa) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ■ Buriet 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 1/14/99 Elkridge, Maryland Meadowridge Mem. Park 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediete Cause (Finet disease or condition resulting in deeth) /Medical Examiner Due to (or es a consequença ot) Examiner physician end the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es a consequença ot): Box 68760 90 Physician/Medical thet initieted events resulting in death) Lest Due to (or es a consequence of) 88 use Pop 23b. Did tobacco use contribute to the cause of death? Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 100 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 🗗 Unknown signed by Division of Vital Records, p 8 24b. Were autopsy tindings aveilable prior to completion of cause of death? Completed 24e. Wes an autopsy performed? hes 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical axeminer? Be 28. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 DInpatient Lo 1 Yes No 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Mennef of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Tima of Certification: After Attending 1 Neturel 5 Panding 1 Yes 2 No death. investigation 2 Accident after death 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicida 28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify) 2 4 Homicide To the Hospital of within 24 hours at To the Funeral D edlcai Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) and menner as stated.

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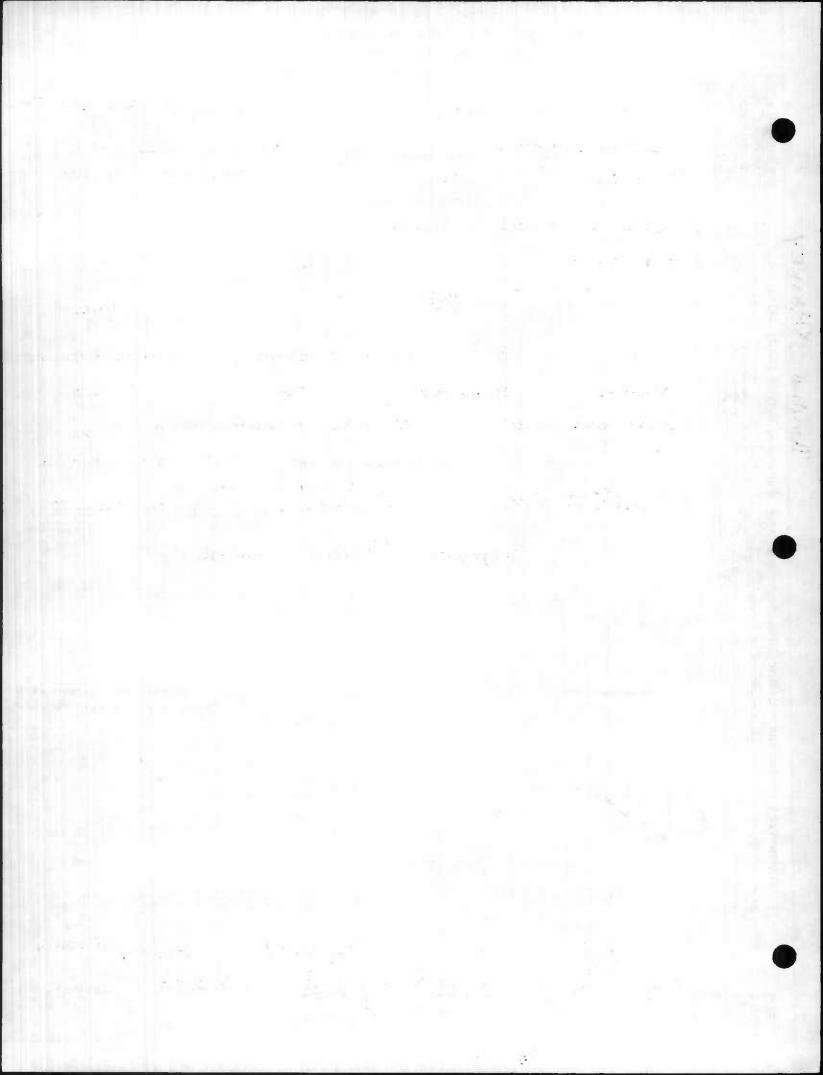
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State of Maryland / Department of Health and Mental Hygiene

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r daath. ector: After by the fune	100	1 Neturet 5 ☐ Pending Investigation	(Month, Dey	Year)	Injury M		rk? Yes 2 □ No						
within 24 hours after death.  To the Funeral Director: After completaly filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not b	e on Disease(1-1-	rv - At hoл	ne, tarm, street, fac	tory, office		28t, Location (	Street end Numb	er or Rural	Route Number.		
after Dire	er	4 Homicide	building, etc	(Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To					
within 24 hours after daati To the Funeral Director: completaly filled in by the		29e. Certifier 1 Certifying Ph	ysician: To the best o	f mu knowl	adaa daath assur	rad at the tim	no data and slag	and due to the	equantal and mu				
within 24 hours of the Funeral I completaly filled	edical	(Check only 2 Medical Examone)	ntner: On the besis of end menner ste	examinetic	n end/or Investigat	tion, in my o	pinlon, deeth occ	urred et the time,	date end placa,	and due to	the ceuse(s)		
the the	Me	29b. Signeture end title of certifier	end mermer ste	5		29c. Licens	e number		29d. Dete signe	d (Month (	Dev Veer)		
3 → 8			121	< (	1=								
2		1/00	- (	_		D4	1955		Januar	y 16	, 1999		
5		30. Name end eddress of person who	completed cause of de	eth (Item 2	23e) (Type, Print)								
		Rebecca Elon,	MD 1454	3 A	A Boul	evare	Arno	ld. MD	21012				
State	е	31. Dete tited (Month, Dey, Year)	0 1000 Registre	r's Signetu	La G		10.11	-,					

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Deeth Month John ah January 18, 1999 2:45am 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Genesis Eldercare, 24 Truckhouse Road Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 10 M 2□ F 714-16-1130 Yrs Sept. 12, 1913 MD Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☑ No Anne Arundel Severna Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 24 Truckhouse Road 21146 U.S.A. 14. Race - American Indian 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 🍎 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Interior Decorator 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Interior Design 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) George E. Stahl Eleanor Asendorf 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 416 Hollyfarms Road, Severna Park, MD 21146 Eleanor S. Meyers (Sister) 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 1/20/99 Baltimore, Maryland Loudon Park Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. Rel 23a. Part1. Enter the disease, or computations that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, 21228 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) lumonia Due to (or as a consequence of): ordernigopat Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or es a consequence of) 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably Munknown 1 Yes 2 No 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2/2 No 1 Yes 2500 25. Wes case referred to medicel examiner? 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 1 Natural 5 Pending

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, end due to the ceuse(s) end manner as steted.

Medicat Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29c. License number

**Physician** /Medicai Examiner The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760

**Physician** 

/Medical

Examiner

Directo

Funerai

à

Completed

Be

**Funeral** 

Director

permit. Peges 1 end 2 should be filed within 72 hours effer death with the Manyland Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natures", or items 23a or 28a-f show any Injury or other traumetic event, the Medical Examinar mass.

Baltimore, Maryland 21215-0020

physician and s the burief-transit attending pl for use es t signed by the a s certificate hes b

Examiner Physician/Medical þ Completed Be 10 funeral Certification:

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice

To the Hosp within 24 hos To the Fune completely fi

edicai

24 hours

State Registrar

who completed cause of death (Item 23a) (Type, Print) M.D. 31. Dete filed (Month, Dey, Year)

investigation

6 Could not be determined

JAN 1 9 1999

2 Accident 3 Suicide

4 Homicide

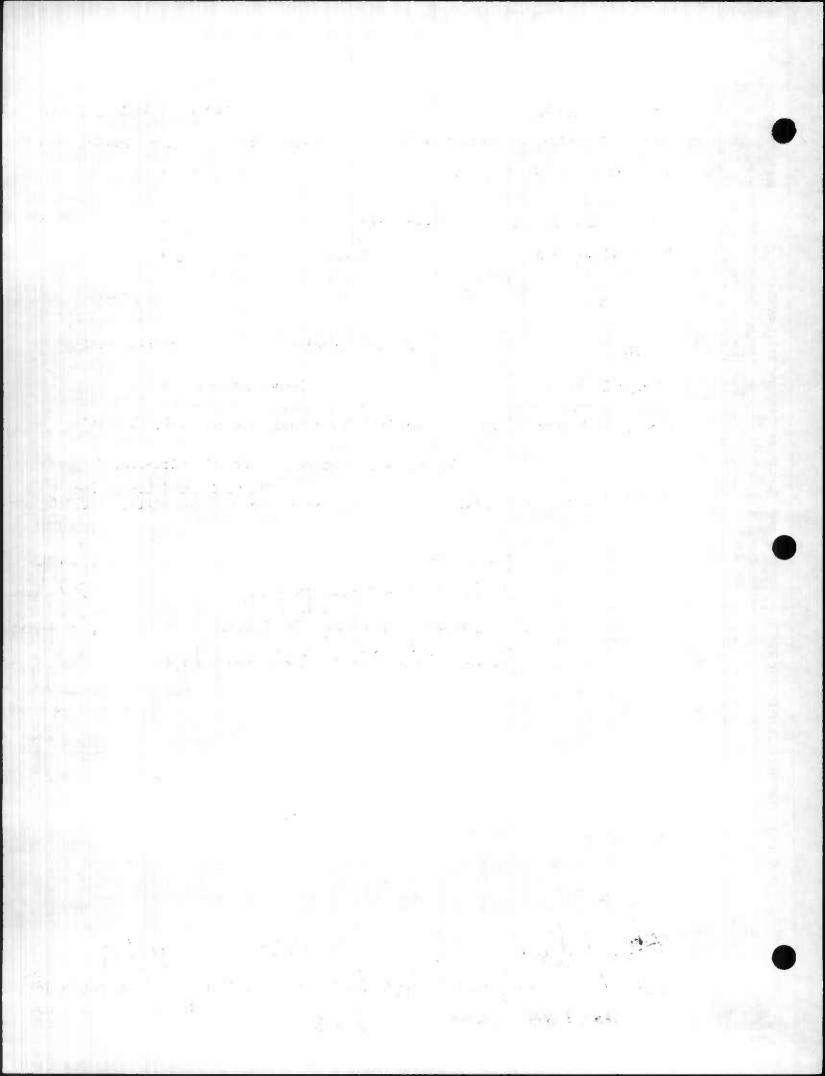
29b. Signature and title of or

29a, Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Dev. Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Betty Shephend 6:40 pm 4b. City, Town, or Location of Death 14 1999 /Medical 4a Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** Baltimore If Under 24 Hrs. The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 2□ F 461-84-3134 51 Yrs. 7/29/1947 Director TEXAS Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show MD HOWARD COLUMBIA 1 ☐ Yes 200No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? natural, or herns 23s or 8503 WINDDANCE WAY 21045 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglens. Elementery/Secondary (0-12) College (1-4or 5+) 5+ TECH. PROJECT MANAGER, V.P. permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygimportant if Item 27 is marked.
any Injury or other the 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM A. SPARKMAN, JR. MILDRED RAE (SAWYER) 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD A. SHEPHERD (HUSBAND) 8503 WINDDANCE WAY COLUMBIA, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/17/99 LAUREL, MD WASH. CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. 5555 TWIN KNOLLS ROAD COLUMBIA, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Fine) Respiratory disaase or condition resulting in death) 3 days Examiner Due to (or as a consequence of): Examiner Breast Concer 3 years physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed l by Records, 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? page 2 s 2/K No 1 Yes 1 Yes 2 No certificate Division of Vital or Attending Physician: efter deeth. director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2NNo Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident Director: / 6 Could not be determined 28f, Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide • Funeral Di Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Brian Jeffersa P25-000 14 1999 JANUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Bultimore Wolfe Md 21287 400 N. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 9 1999 Registrar

DHMH 16 Rav 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) PM **Physician** - CORGR SNEAD JANUARY /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** BALTIMORE GillcresT IOWSON Hospice center If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 9. Birthplece (State or Foreign Country)
A. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** 100M 20 F Deys 182-16-2473 Yrs. Director Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Wool cal Examiner mast be notified at 1 Yes 2 No NIA BALTIMORP MD Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number USA 571 New ItoIm AUC 21206 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Meritel Status 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married 1 Yes 2 No Specify: while Specify: by 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) IDUSTRIAL, CO. MACHINIST NIA 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) permit. Peges 1 end 2 should be Department of Health end Mental Important: If Itam 27 is marked o eny Injury or other treumstic eve WALTER . J. Ruth COST 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 5719 Newholm-Aux BALTO, MD JUEAD MYS SYLVIA 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Buriel 2 □ Cremetion 3 □ Removel from State 18 99 Rosedale Frith 1 4 ☐ Donetion 5 ☐ Other (Specify) GARdens of 22. Name and Address of Facility

HARTLEY MILLER FUNERAL It ONE CHTD.

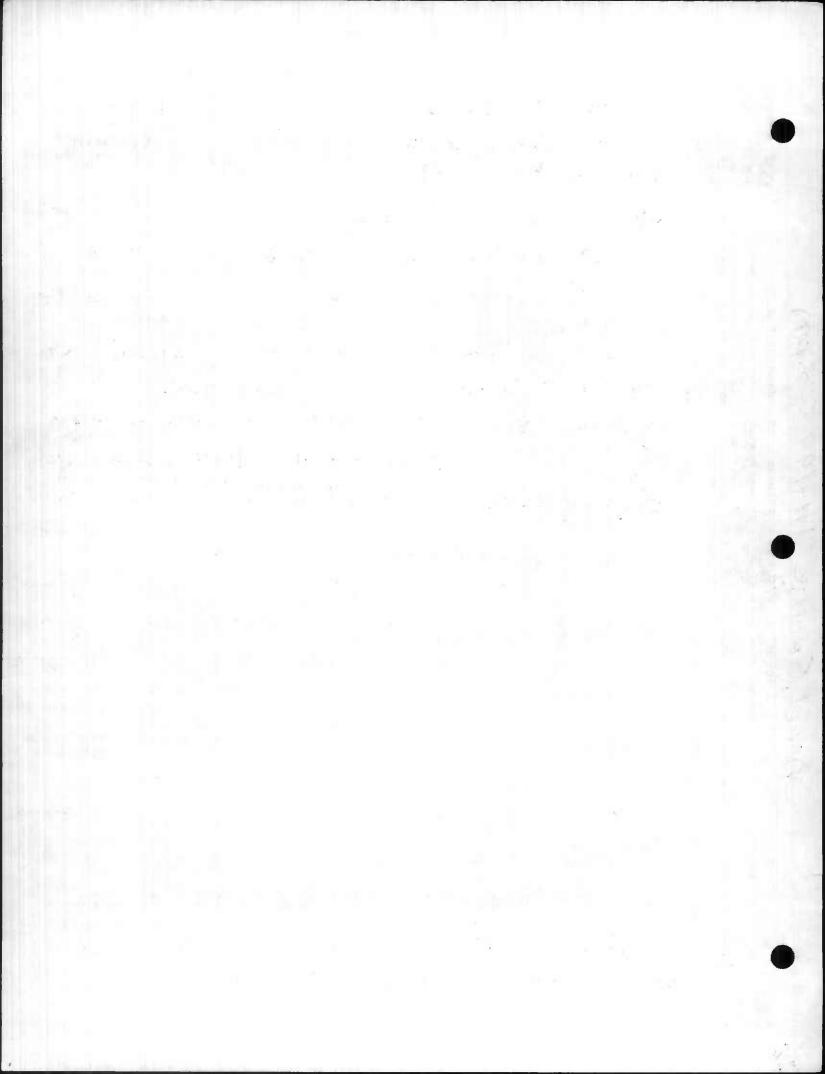
1527 It as Ford RD BACTO-MA 21334

21. Name and Address of Facility

To be a complication that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest,

Approximate the control of the cont 21. Signature of Funerel Service Licenses Approximete Interval Between Onset end Deeth **Physician** Immediete Cause (Final disease or condition resulting In deeth) /Medical Examiner Physician/Medical Examiner physician and the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): 7 CM 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. the state 1 Yes 2 Probably 4 Unknown ρ 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Physician: Be 25. Wes cese referred to medical 26. Piece of Death (Check only one) 10 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Hother (Specify) Hospice 1 Yes 2 No this funeral 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28e. Dete of Injury (Month, Dey Year) After 5 Pending investigation 1 Neturel 1 Yes 2 No n 24 hours efter death.

• Funeral Director: All pletely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner as stated (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, In my opinion, deeth occurred at the time, date and piece, end due to the cause(s) end menner steted. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier ino 30. Negre end eddress of person who completed cause of deetly (Nem 23e) (Type, Print) W. A. Riley G. BMC 670 i N. Chr. Charles St. Batto md 2120x 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State JAN19 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** January 14,1999 1:15 A.M Marie Theresa Sadler /Medical 4a Facility Nama (If not institution, giva street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Rosedalc Franklin Square Hospital Center
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | Hunder Baltimore If Under 1 Year Birthpiaca (State or Foraign Country) 5. Social Security Number If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) **Funeral** Days Months Hours 1□M 200F 218 18 8078 76 Director 25,1922 Maryland Aug. Usual Rasidence of Decedant 10h Counts 10c. City, Town or Location 10d Inside City Limits than "natural", or Hema 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yas 2 No Maryland Baltimore Director Essex 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after deeth with Department of Health and Mental Hygiene. Innoctant: If Item 27 is marked other than "natural", or Hema 23a or any injury or other traumatic event. 1300 Old Eastern Avenue 21221 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - Amarican Indian, Black, Whita, atc 1 Yes 2 No
If Yes, Giva
Year or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 DXNo Specify: White Specify: P 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elemantary/Secondery (0-12) College (1-4or 5+) Provider Day Care 11 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Maidan Sumama) Be Louis Kenny Mary Kujwa 19e. Informant's Neme/Retationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Martin (Son) 10 W. Semminary Ave. Timonium, Md. 21093 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 1/16/1999 Greenmount Crematory Baltimore, Md. 22. Nama and Addrass of Facility re At Funeral Service Ligenser Bruzdzinski Funeral Home P.A. rouse 1407 Old Eastern Avenue Essex, Md. 21221 Fur1. Entar tha disease, or complications that caused tha death. Do not entar tha mode of dying, such as cardiec or respiratory arrest, thack, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final · Cerebral Vascular Accident disaasa or condition rasulting in death) Examiner Due to (or as a consequence of) Examiner per tension physician and the burial-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Coronary Artery Disease, Diabetes signed b Records, 24b. Ware autopsy findings available prior to Completed 24a. Was an autopsy performed? Mellitus Type 2, Myocardial Infarction completion of causa of death? 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was casa referred to medical axaminar?
1 ☐ Yas 2 No Be 26. Place of Death (Check only ona) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Medical Certification: To 27. Mennar of Death

1 Natural
2 Accident 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation 1 ☐ Yas 2 ☐ No 6 Could not be 3 Suicide Plece of tnjury - At homa, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Ruret Routa Number, City or Town, State) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mannar as stated.

Medical Examiner: On the bests of axamination and/or investigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and menner stated. 29a. Certifier 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year)

19

DHMH 16 Ray 6/95

State Registrar 31. Date filed (Month, Day, Year) JAN 1 9 1999

Barker

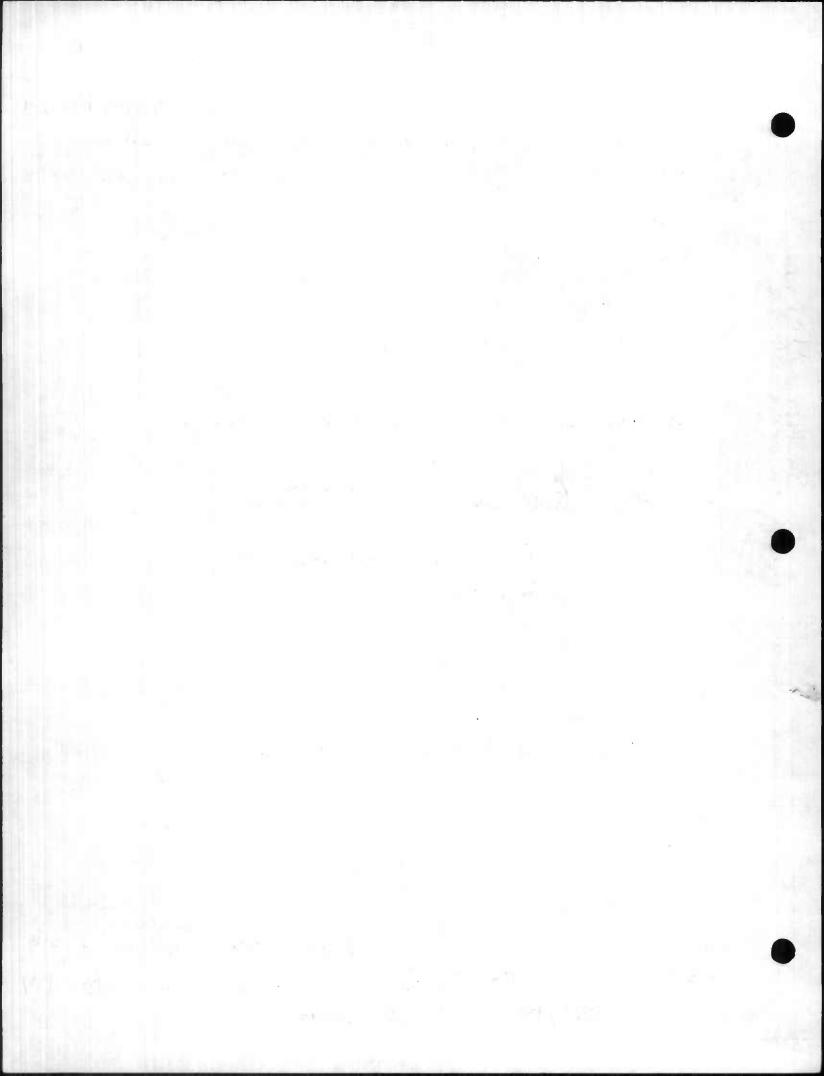
32. Regintur's Signatura

completed cause of death (Item 23a) (Type, Print)

Hin Square Drive Baltimore, MD 21237 B. Sparks

191809

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedant's Nama (First Middle Last) 2. Data of Death 3. Time of Death Month 14, 1999 January Glenn Patrick Smith 5:28 pm 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 530 Eastern Blvd. Baltimore Essex If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Dey, Yaer) 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Months Days Hours Min 1 M 2 □ F Yrs. 38 212 78 4237 Feb. 4,1960 Maryland Usual Rasidanca of Dacedani 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 331 Essex Avenue 21221 USA 12. Was Decedant Evar in U,S Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Biack, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Never Married 2 X Married 1 Yas 2 No White Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kInd of work dona during most of working lifa. DO NOT usa retired) Flamantary/Secondary (0-12) Coilega (1-4or 5+) Baltimore, County Bus Driver 12 18. Mothar's Neme (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) John A. Smith Sr. Barbara Ochse 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Deborah L. Smith (Wife) 331 Essex Avenue Baltimore, Md. 21221 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cramation 3 ☐ Removal from State Gardens Of Faith Cemetery1/18/1999 Baltimore, Md. 4 ☐ Donation 5 ☐ Othar (Specify) of Funarai Sarvica Licansas 22. Nama and Addrass of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 Durkouse 23a Part. Enter the disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, or hourt failura. List only one causa on each line. Approximate Intervat Between Onsat and Death Immediate Ceuse (Finel disease or condition resulting in deeth) Sequantially list conditions, if any, laeding to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initieted avants rasulting in daath) Last Dua to (or as a consequence of) Dua to (or as a consaquanca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 → No Nown

**Physician** /Medicai Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Directo

Funeral

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Completed

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72 hours after death

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Hygiena.

12 should be f h and Mental H

other

Is marked

permit. Pages 1 end 2 sh Department of Health and Important: If Itam 27 Is m any Injury or other traum pncs.

Baltimore, Maryland 21215-0020

Examiner nding physicien end use as the buriel-transit Physician/Medicai use as t etter ed by the e signed by t by Completed peen has page 2 certificata Be 10 this funeral After

certificete be executed death law requires that the The Physicien: Attending death. s after death.

I Director: A
od in by the fo 6

Box 68760, o 0 Division of Vital Records, filled in

within 24 hours a completaly 3 State Registrar

Certification: edical

3 ☐ Suicida

29a, Cartifian

4 | Homicida

(Check only one)

29b. Signatura and titla of certifier

Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part t. 26. Placa of Death (Chack only ona) Deceased Business Loc 25. Was casa rafarred to medical axaminar? Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 X Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28c. fnjury at Work? 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Tima of 1 (2Natural 5 ☐ Panding 1 Yes 2 No Invastigation 2 Accident

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 6 Could not be datarmined

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 1 Certifying Physician: To tha bast of my knowledge, death occurred at tha tima, data and placa, and due to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at tha tima, dete and placa, and dua to the cause(s) and manner stated.

24a. Wes an autopsy performed?

1 Yes 2 No

24b. Ware eutopsy findings available prior to

complation of cause of deeth?

1 ☐ Yas 2 ☐ No

29d. Date signed (Month, Day, Year)

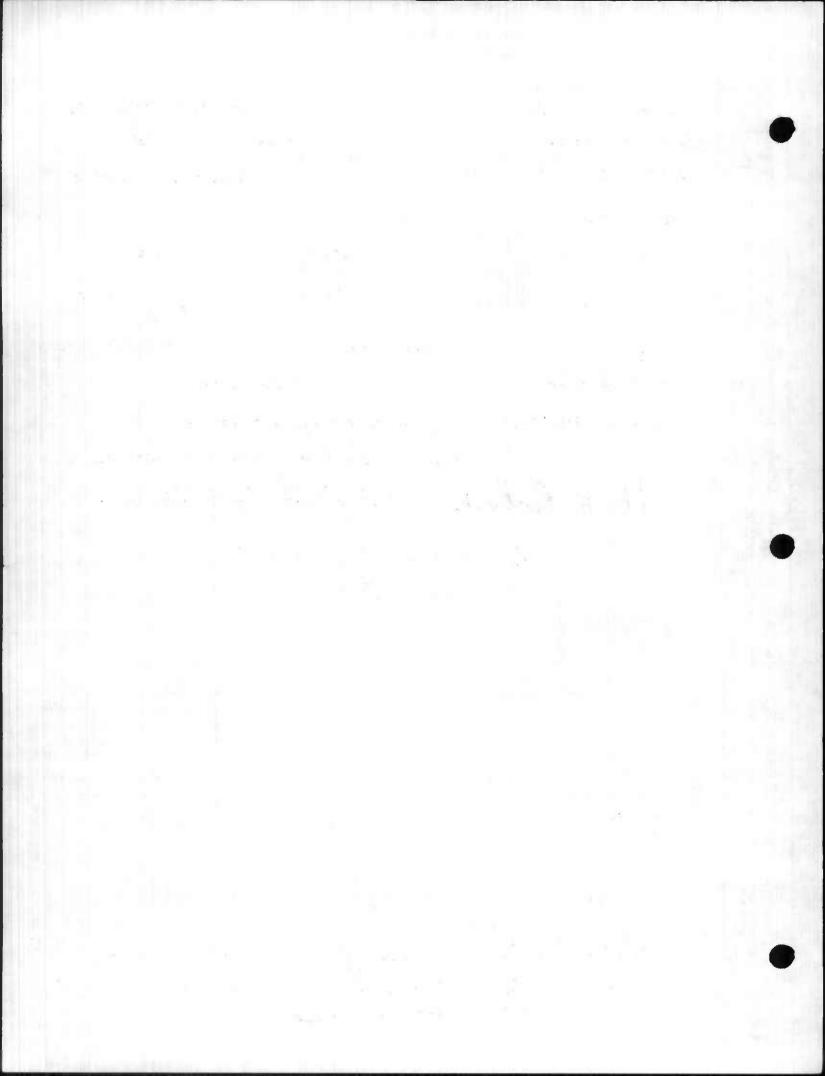
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30. Name and addrass of person who completed causa of death (tem 23a) (Type, Print) 10 5

31. Data filad (Month, Day 32. Ragistrar's Signatura 1999 9

29c Licanse numbe



Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Sylvia Smith Month **Physician** 10:30 14 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UMMS BALTIMORE
If Under 24 Hrs. 8. Date of Birth
Hours | Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 212-32-5701 Usual Rasidence of Decedant 6 Yrs. **Director** HARCH 21, 1937 MAR 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1€ Yas 2 No ns 23a or 28a-f a Directo MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? natural, or items 23a BALTIMORE STREET 15A. Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yas 2 No If Yes, Give Year or Dates: Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC WORKER SELF-EMPLOYED 11+HGRADE d 2 should be filed w In and Mental Hygies 7 is marked other th 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is merked i any Injury or other traumetic ev-SEWEL 2 UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Data

20c. Location - City or Town, Stata TREA SMITH (DAUGHTER 20a. Mathod of Disposition

1 ■ Burial 2 □ Cramation 3 □ Removal from State ATIONAL CEMETERIOI-19-99 LAUREL, MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility Puneral Service Licensee 21. Signature BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNERAL HOD 2140 N. FULTON AVE. BALTIMORE, MD. 212 Approximata Interval Between Onset and Death the disaasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiretory are **Physician** /Medical Immediata Causa (Final Hypotension
Due to (or as a consequence of): disaase or condition resulting in death) Examiner Amythmia physiclen and s the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last End Stage Renal Disease Division of Vital Records, P.O. Box 68760 Physician/Medical Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? hes 1 Yes 20 No 1 ☐ Yas 2 ☐ No certificate Be 25. Wes casa rafarred to madical examinar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Mannar of Death 28a. Deta of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Panding invastigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Netural 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar edicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifiar undurann MD P10232 atherine C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

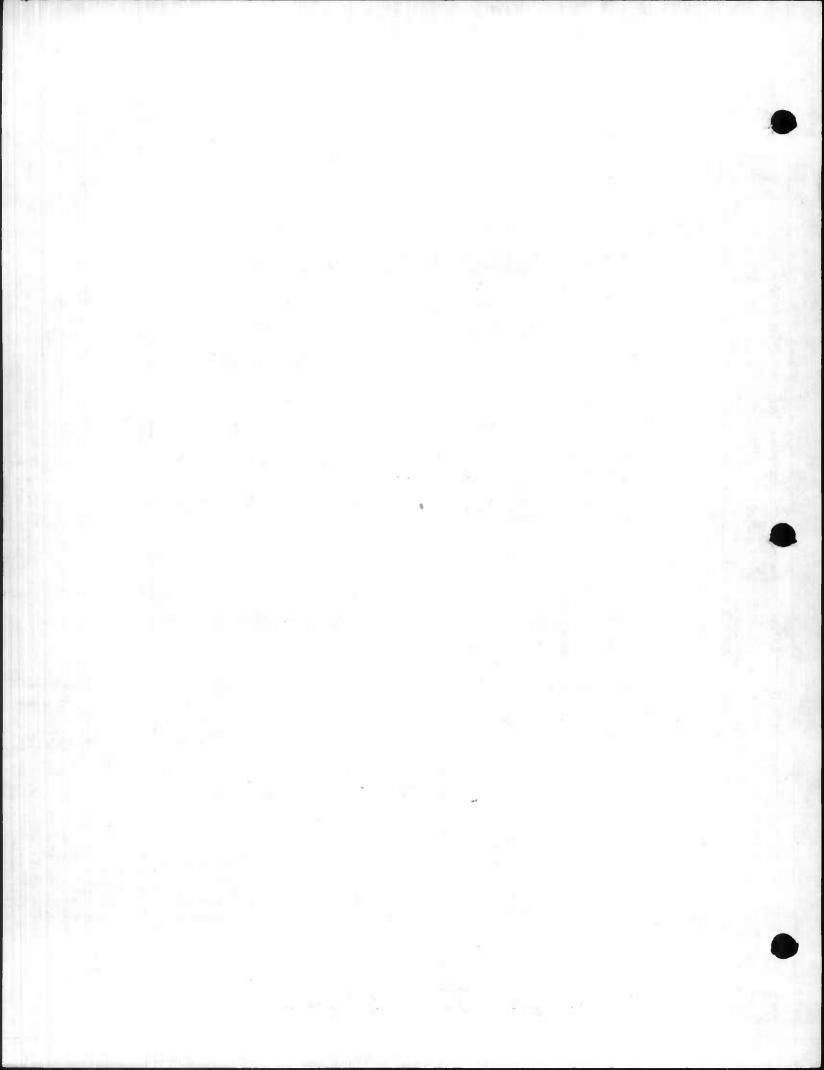
Kathenne Grundmann 225 Greene ST, Baltimore MD 191999 Registrar Scionature 31. Data filed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

State

Registrar

JAN



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima ol Death **Physician** ORINE STEVENSON 3:40am GARRETT JANUARY 13, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GIEN BURNIE A.
If Under 1 Year | If Under 24 Hrs. 8 Date of Birth (Month, Day, Year) NORTH ARUNDEL HOSPITAL A.A.COUNTY 5. Social Security Number

20-24-40/

Usual Residence of Decedent 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 2♥F Months Yrs. Director 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director GLEN BURNIE MARYLAND ANNE ARYNDEL CO 10e. Street and Number 10g. Citizen of What Country? 8037 SOLLEV ROAD USA, 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mentel Hygiene. Important: if Nem 27 is marked other than "natural", or a sary injury or other treumatic event, tre Medical Parama 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3)☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6+HGRADE AIDE A. A. Co. PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) OLLIE (JARRETT GERTRUDE TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8037 SOLLEY ROAD, GLEN BURNIE, MD. 21060
pe of Disposition (Name of Date 20c. Location - City or Town, State ALEATHA STEVENSON (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 'S CHURCH CENETER OI-16-99 GLEN BURNIE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility, JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTONAVE., BALTIMORE, MD. 2121 21. Signature of Funeral Service Licenses Slows 2140 N, FULTONAVE, BALTIMORE MO. 2121

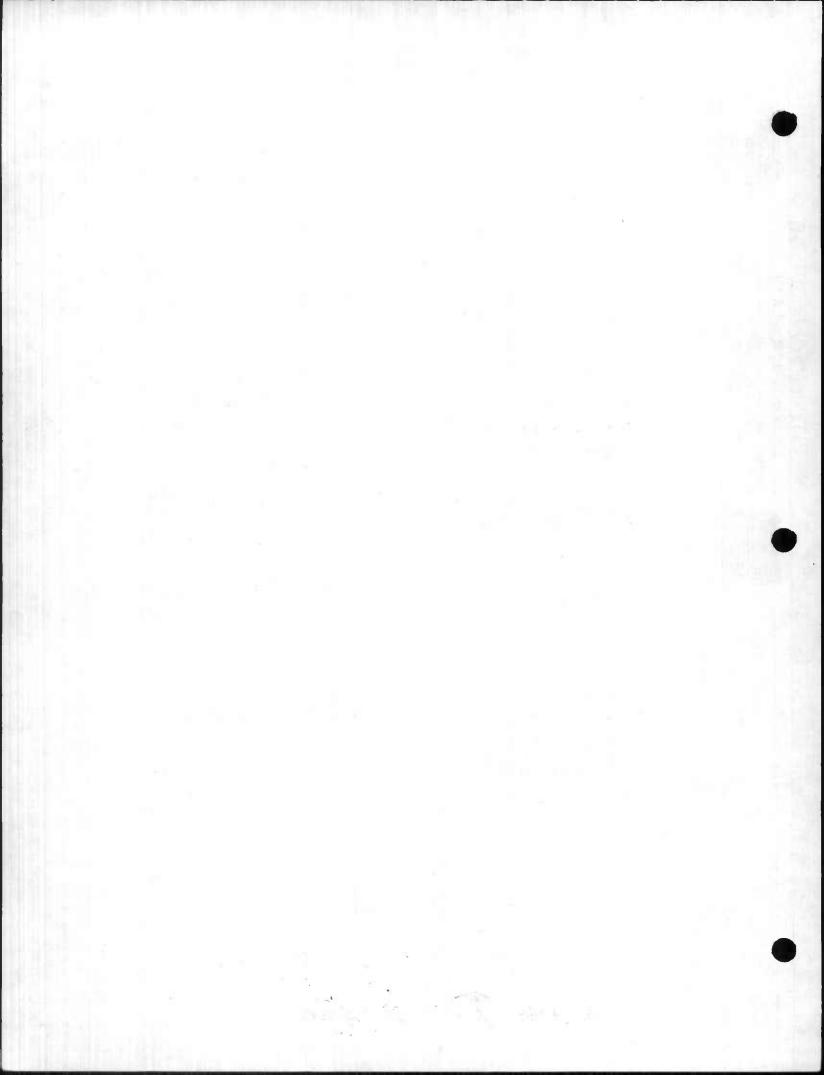
Approximate Interval Between Onset and Death

Onset and Death Physician Cerelovareular Accident /Medical Immediate Cause (Final disease or condition resulting in death) Examiner evelovercular Aceden Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown Records, 24a. Was an autopsy performed? 24b. Were autopsy lindings available prior to completion of cause of death? 1 Yes 2 X No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 1 A Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Division Attending 5 Pending investigation deeth. 1 Yes 2 No To the Hospital or Attendi within 24 hours effer deeth. To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 ☐ Homicide 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D21684 1-13-1999 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) ( Whywar M) PASABRNA, MO 21122 C-V. CTRIAC. M.D. 8109 RITCHIR BUY, 32. Registar's Signature 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State Registrar

STEVENSON



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Day SIMPSON ERVIN 1999 7:05 PM JANUARY 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death BALTI MORE If Under 24 Hrs. 8. Date of Bi HOSPITAL AGNES If Under 1 Year 6. Sex 10 M 2□ F 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 214-46-9383 Usual Residence of Decedent Months Deys Hours Min. Yrs. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE Ves 2□ No MARYLAND 10g. Citizen of What Country? 10e. Street and Number 4624 USA AVENUE Was Decedent Ever in U,S. Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: BLACK 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 11 TH GRADE ONDUCTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HANDLER KOBERT 19b. Mailing Address (Street and Number or Runal Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4624 FREDERICK AVE. BALTIMORE, HD, 2/229 20c. Location - City or Town, State ECELIA SIMPSON Place of Disposition (Name of cemetery, cremetory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State CEMETERY 01-23-99 ARBUTUS, MARYLAND 4 Donation 5 Other (Specify) e of Funeral Service Light 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIMORE, MD. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death MYUCARDIAL INFINED AN ACVIR tmmediate Cause (Final disease or condition resulting in deeth) UNKNOWN Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Munknown NEUMONIA 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? DISEASE ARTRAY 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medicel examiner? 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ F/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of 28c. tnjury at Work?

**Physician** /Medical Examiner

pormit. Pages 1 and 2
Department of Health en.
Important: If item 27 is m.
any Injury or other.
DRGs.

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

Be

Director

d 2 should be filed within 72 hours after death with the Merylen th end Mentel Hygiene.
7 Is marked other than "natural", or thems 23s or 28s-f show traumetic avent, or Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

P.O. Box 68760.

of Vital Records,

Simpson

Examiner Physician/Medicai SB þ Completed

2

1 Setural

2 Accident

3 Suicide

29a. Certifier

4 Homlcide

(Check only one)

29b. Signature and title of certifier

Certification:

edical

physician and the burial-transit esn funeral After

hours after deat 24 hours within 2

State Registrar **DHMH 16 Rev 6/95** 

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

5 Pending Investigation

6 Could not be determined

comos 57 JAN 191999 Signature

Zns

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🔀 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

> MUSPITAL AGN 03

29c. License number

1 Yes 2 No

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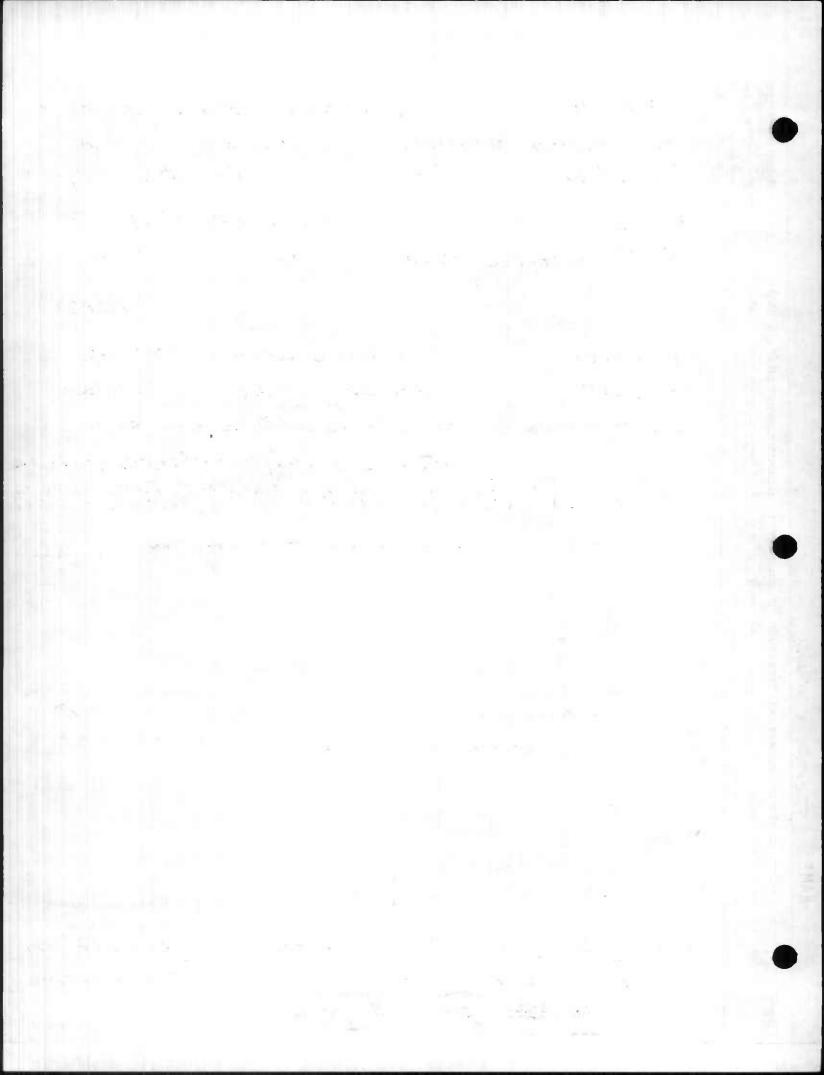
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

BALTIMONS MJ

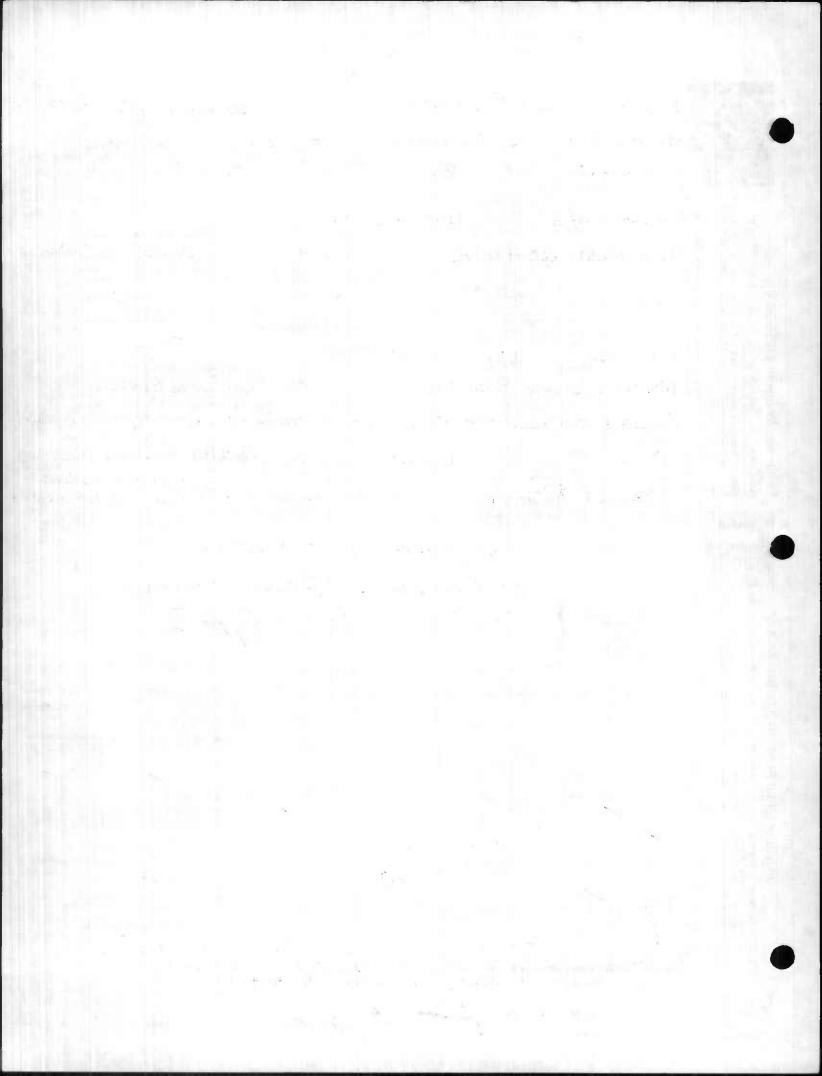
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/Medical Examiner	disease or condit rasulting in death.  Sequentielly list c if eny, leading to cause. Enter Unc Ceuse (Disease c that initieted avan rasulting in death)	onditions, mmadiata llarlyIng r injury ts Last	c	Dua to (or as	s a consequent s a consequent	ce ot):	JAC.	INFA	MON	17	2 hours
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Month **Physician** 8:45 A.M. ELIZABETH ANNA SLAUGHTER 1999 JANUARY 14 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner GENESIS ELDERCARE-MULTI MEDICAL BALTIMORE Towson
If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Deys Months Hours Min. 1 M 2 5 F 217-22-9453 89 Yrs. JUNE 11, 1909 MARYLAND **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at with the Maryle BALTIMORE CITY 1⊠Yes 2□No MARYLAND N/A Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES OF AMERICA 21214 2820 WESTFIELD AVENUE Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 MWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TAILORING SEAMSTRESS NIA 12TH GRADE 7 is marked other traumatic avent, 18. Mother's Name (First, Middle, Malden Sumeme) 17. Father's Neme (First, Middle, Last) permit. Pages 1 and 2 should be filt Depertment of Heelth and Mental Hy Important: if flam 27 is marked oth any linjury or other traumatic avent bates. Be MARTIN CLEMENTS SCHATTNER MARY CATHERINE SAUTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pont) PAMELA L. BUTTNER/GRANDDAUGHER 1333 DARTMOUTH AVENUE BALTIMORE, MARYLAND 21234 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition BALTIMORE, MARYLAND 1 ■ Burlai 2 □ Cremation 3 □ Removal from State JAN. 16, 1999 OAKLAWN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee 6009 HARFORD ROAD ALTENBURG FUNERAL HOME, P.A. BALTIMORE, MARYLAND 21214 Sonald R. Watson, 23a. Part1. Enter the disease, or complications the coused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner as the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury requiras that the death certificete be avacu Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last attending USB signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 € Onknown 1 | Yee 2 | No þ 24b. Wara autopsy findings available prior to completion of cause of death? been sig Completed 24a. Was an autopsy performed? Is certificate hes director, page 2: 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Yeer) 28d. Describe how Injury occurred 27. Manner of Death 1 Denatural 28b. Time of Certification: or Attanding 5 Pending investigation VA 1 Yes 2 11€ deeth. Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Dirac completely filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier fur ber Am org, M.D. D13649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NESTOR, M. CARNON & BALTIMORE, Md. 21214 12040 6012 HARF0120 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State JAN 191999 Registrar



State of Maryland / Department of Health and Mental Hygiene

					Certificate	of Death		Reg. No.	JU	0833
Physic	ian	Decedent's Neme (First, Middle					2. Date of D Month	eeth Dey	Yeer	3. Time of Deeth
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Funera	ı	Greater Balti 5. Sociel Security Number	6. Sex 7. A		Months Di	eer If Under 24 H	rs. 8. Date of B	rth (199, 1925	9. Birthpl	ece (Stete or Foreign
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trylar show		10e. Stete 10b. County		10c. City, To	own or Location				10	Od. Inside City Limits
W W	Director	Maryland N/A		Ba	altimore					1 No Yes 2 No
4 28 Y	ē	10e. Street and Number			10f. Zip Coo	de		10g. Citizen of	Whet Count	ry?
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72 hours effer death with the Maryland "natural", or flems 23a or 28a-f show adost Exampler must be notified at	Funeral	11. Maritel Status	12. Was Decedent	Ever in U,S.	13. Was Decedent	of Hispenic Origin? Cuben, Mexican, Pu	(Specify Yes or N	o- 14. Red	ce - Americe	
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permit. Peges 1 Depertment of I- Important: If its any injury or ot		21. Signeture of Funerei Service I	icensee		22. Name end A			. 1 11		
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Examiner		disease or condition resulting in deeth)	Θ	-7	60012				-	says
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that the deeth	/sic	Pert II. Other significant conditio	s contributing to death !	but not resulting	in the underlying ceuse	given In Pert f.	23b. Did	tobacco use co	ntributa to	the cause of death?
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fter of Irec	T.	4 ☐ Homicide determi	ned 288. Piece of in	ijury - At home, tc. (Specify)	ferm, street, fectory, off	ice		(Street end Numi wn, Stete)	er or Rural	Route Number,
is e si pel										
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To the Hospital or Attending Ph within 24 hours etter deeth. To the Funeral Director: After th completely filled in by the funeral		and and and and and and and and and and	end menner si	lated.	and the suggestion, in the	., opinon, deem oc	Out of the fittle	cere enu piace,	WILL GOS 10	110 00038(5)
With To t	2	29b. Signature and time of certifier			29c. Lld	ense number		29d. Date signe	d (Month, E	Jey, Year)
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y			WASTZM		(Type, Print) FITE, M	0/00/0	Avo 2	1212		
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Director

Funeral

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State of Maryland / Depa

	2. Data of Death		3.1	ime of	Death
tificate of Death	Reg. No.		08	31	1
intment of Health and	Mental Hygiene	0 0	00	01	

10:03 PM.

10d. Inside City Limits

Approximate Interval Between Onset and Death

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

JANUARY 14, 1999

1 Yes 2 No

OLIMITATIO	TAI			Certificate of Deati	1	Reg	. No.	_
Physician	Carc		Shamanski			2. Data of Death Month JANUARY	Day	Year 1999
/Medical Examiner	4a Facility Name (If not institu UNION MEMO)					cation of Death		unty of Death
	5 Social Security Number	6 504	7 Ann /In ure las	t hirthday) If Under 1 Year If Under	r 24 Hrs.	9 Date of Birth		N/A

**Funeral** Director

the Maryland Show "natural", or itema 23a or 28a-f ahor edical Examiner must be notified at death with

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If Item 27 ie marked other than "natural". ce length injury or other treumatic exercises yilly or other treumatic exercises.

**Physician** /Medical Examiner

Box 68760

P.O.

Records,

Division of Vitai

Examinet physician and s the burial-transit that the death certificate be assocuted Physician/Medical \$ P 2 signed b þ The law requires should Completed page 2 s Amending Physician: Be Certification: To this After within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu 6 Hospital Medical

27. Manner of Death

1 Natural

2 Accident

4 Homicide

29b. Signatura and fitta of certifiar

3 ☐ Suicide

29a. Certifier (Check only one)

5 Panding Investigation

6 Could not be determined

9. Birtholace (State or Foreign Months Davs Hours 1□M 27 F Maryland 37 212-90-3614 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location Dundalk Maryland Baltimore 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 976 Elton 21224 U.S.A Avenue 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, Black, White, etc. 1 Yas 2 No 1X Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grads completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembley Line Work Hedwin Corp. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Daniel T. Shamanski Elsa M. Leichtle 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry W. Ray, Sr. (Fiancee) 714 Berry Street, Baltimore, Maryland 21211 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State XXSurial 2 Cremation 3 Removal from State 1/18/99 Stanislaus Cem Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility 21. Signature of Funeral Service Licensee A. Alan Seitz, Jr. Funeral Home 3818 Roland avenue, Baltimore, Maryland 21211 6 23a. Part 1. Enfar the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. atherosclerotic Immediata Causa (Final disease or condition resulting in deeth) LIOVORSC Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that infliated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yas 2 No 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) examiner/ 1∑ Yas 2□ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 【XER/Outpatient 3 ☐ DOA

State Registrar

030Ph aner 31. Date filed (Nonth, Day, Year) 32. Regisfrage Signature JAN 191999

Carre 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

28a. Dete of Injury (Month, Day Year)

111 Penn Street, Baltimore, Maryland 21201

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

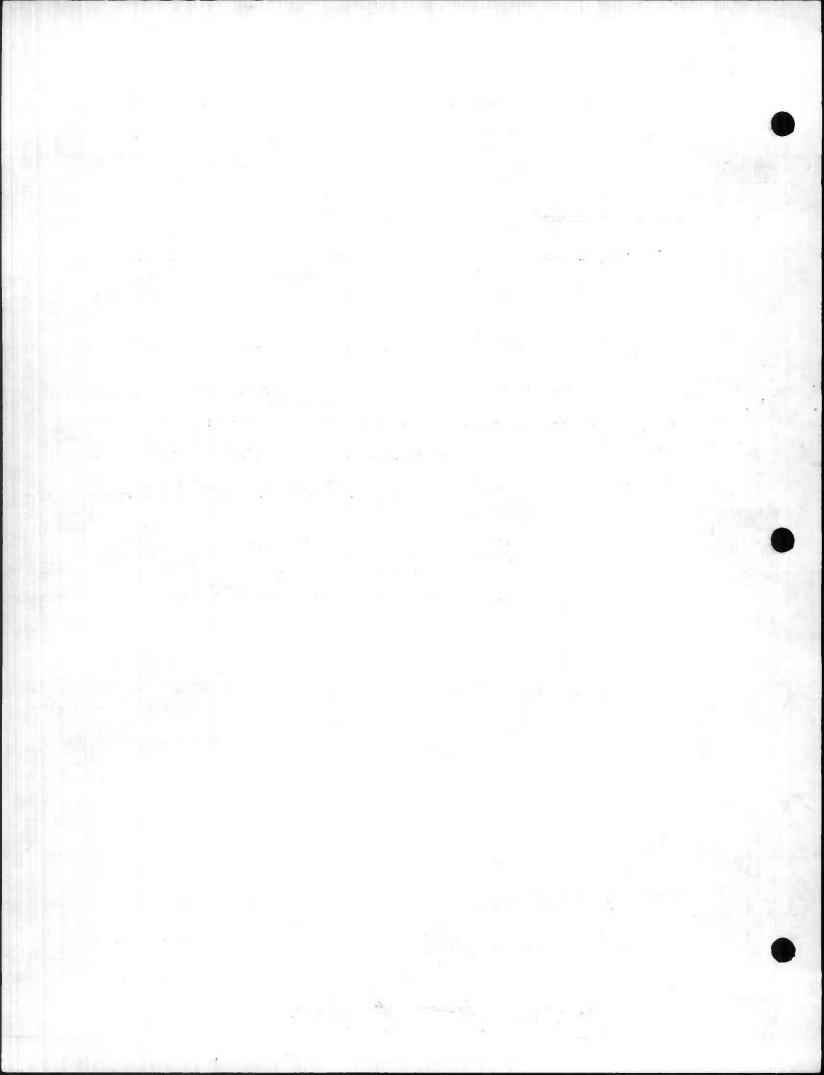
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**DHMH 16 Ray 6/95** 

To the within 2

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \( \text{Q} Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Day Year TRUSTY 0:10AM SARAH January
4b. City, Town, or Location of Death 14, 1999 4a Facility Name (If not institution, giva street end number) 4c. County of Death BALTIMORE HARBOR HOSPITAL CENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Months Days Hours 1 M XXF 67 Yrs. 159-26-5696 MAR 7 1931 SOUTH CAROLINA Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 20 No MARYLAND ANNE ARUNDEL GLEN BURNIE 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6571 BOOKER AVENUE 21060 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11 Marital Status Bleck, White, etc. 1 Never Merried 20 Married 1 Yas 2 XX Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 9th grade MACHINE OPERATOR FOOD SERVICE 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) ADDIE LINTON FRANK COOPER 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 6571 Booker Avenue, Glen Burnie Maryland 21060 Charles E. Trusty/Husband 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Donetion 5 Other (Specify) 1 - 20BALTIMORE, MARYLAND CEDAR HILL CEMETERY 22. Name end Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 21. Signeture of Funeral Service Lice isee mellari 1206 W. NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failura. List only one cause on each line. Approximate Interval Between Onset and Death HEPATORENAL SYMDROME Immediete Cause (Final 5 DAYS disease or condition resulting in deeth) Due to (or as a consequence of): YEARS CIRRHOSTS OF LIVER Due to (or es e consequence of): HYPERKALEMIA Due to (or as a consequence of): COAGULAPATHY 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown ENCEPHALOPATHY

**Physician** /Medical Examiner

physician and s the bunal-transit

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Box 68760.

P.O.

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of Vital

Division or Attending

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Examiner

Physician/Medical

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Completed

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After

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

**Physician** 

/Medical

Examiner

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Director

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Completed

Be

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or Item eny injury or other treumatic event, the Medical Examples page.

Baltimore, Maryland 21215-0020

death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

HEPATIC

HEPATITIS C

ANEMIA

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed?

1 Yes 2 No

26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 No

25. Wes case referred to medical axaminar? 1□ Yes 2 No 27. Manner of Death 1 Neturel
2 Accident

28a. Dete of Injury (Month, Dey Year) 5 Pending investigation 6 ☐ Could not be

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier

Dig Tay-OKES RESIDENT PHYSICIAN P12136

29d. Data signed (Month, Day, Year) January 14, 1999

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) QING

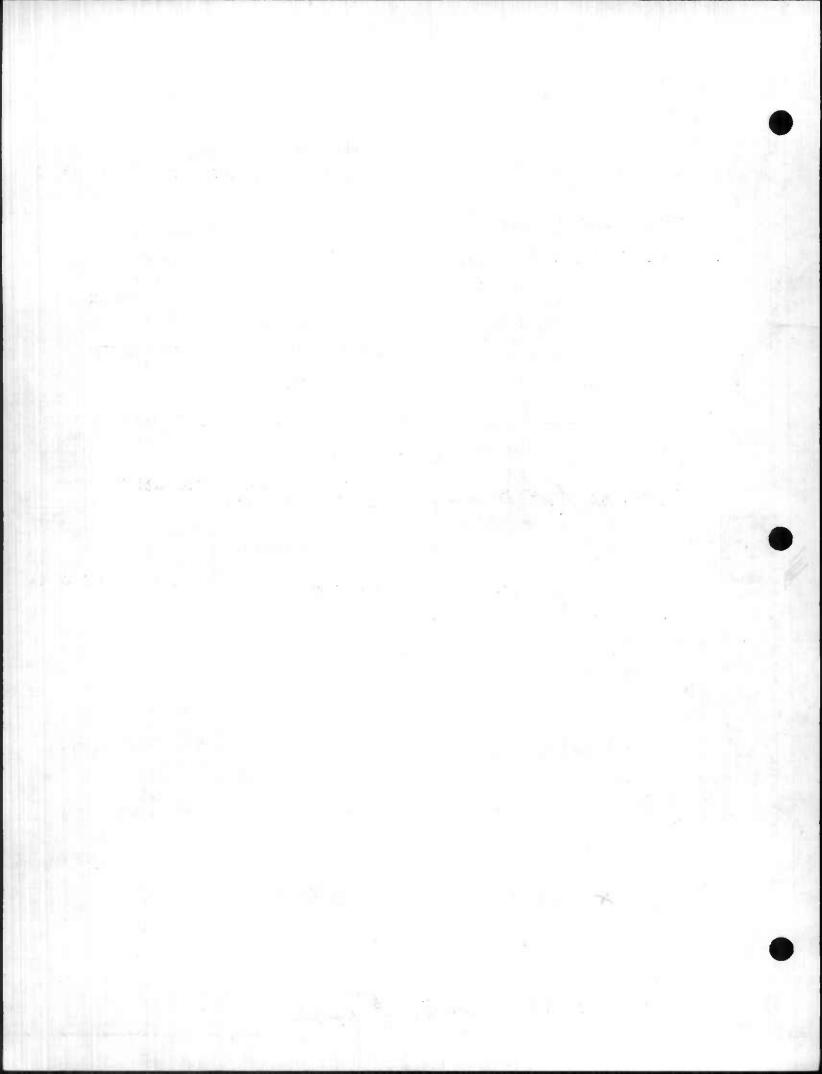
TANG-OXLEY, MD. 3001 SOUTH HAHOVE STREET, BALTIHORE, MD & 1225

State Registrar

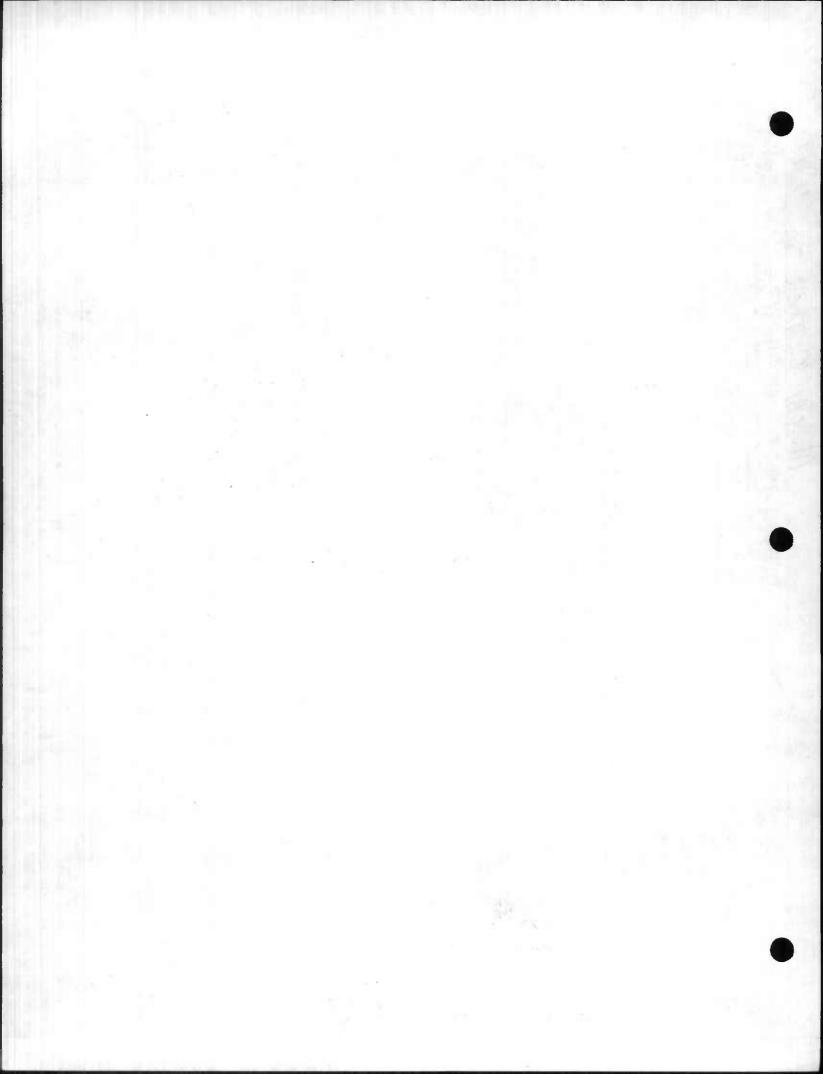
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31. Data filed (Month, Day Year) 1 9 1999 32. Registrii Signeture



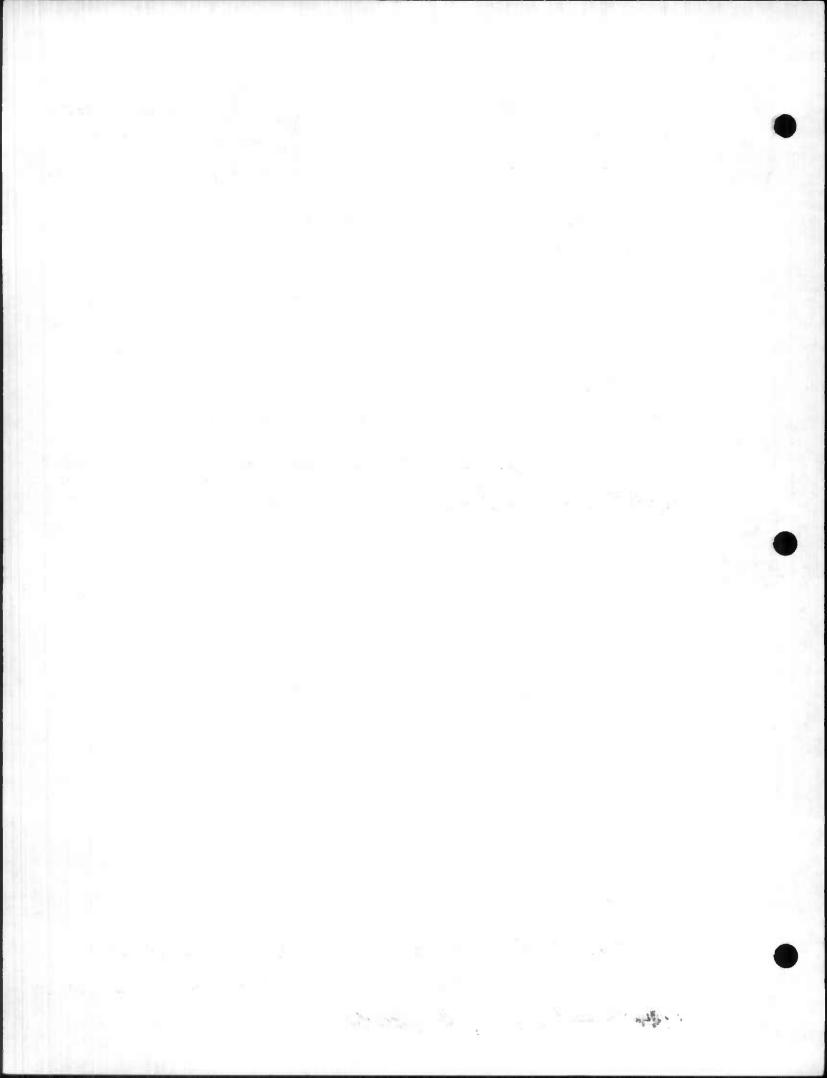


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 30 AM State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death Dey Month **Physician** MURRAY CALDWELL TAYLOR, JR. P. 30 am /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Southerly Court, Apt. 407 Security Number 6. Sax 7. Age (In yrs. last birthday) Towson Baltimore If Under 1 Year | If Undar 24 Hrs. Months Deys Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** 1 M 2 F Months 156 -01-8814 Director -18-21 Maryland Usuel Residence of Decedant 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Nerns 23s 3 Southerly Court, Apt. 407 21286 USA Funeral 12. Was Decedent Evar In U.S. Armed Forcas? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. Armed Forces:
15 Yes 2 No WWII & Yes, Give WWII & Year or Dates: Korea 1 ☐ Nevar Merried 2 ☐ Married "natural", or 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens important: if them 27 is marked other than any Injury or other traumate. Elamentary/Secondery (0-12) Collega (1-4or 5+) Salesman Business Systems 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Helen Kalstrom Murray Caldwell Taylor, Sr. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 3 Southerly Ct., Apt. 407 Towson, MD 21286 Marjorie B. Taylor/Wife 20b. Pleca of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 01/16/99 Baltimore, 21. Signature of Funerel Service Licenses 22. Name end Address of Fecility.
Cremation Society of MD, Inc. Gregorchik 299 Frederick Road Baltimore, MD 21228 Edward A. 23e. Part1. Enter the disease, or complications that caused tha deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical myarardial infaction menutes Examiner Due to (or as a consequenca of): Examine Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequença of): Box 68760. physical Physician/Medicai Due to (or as a consequence of): P.O. 23b. Did tobacco-dee contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not rasulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown emphysema Records, þ 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 90ad 1 Yes 2₽No 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To this 26a, Deta of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer Division or Attanding 1 Neturel 5 Pending investigation To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28l. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29c. Licensa number 29b. Signature and that of certifier aseulles D24121 30. Name end address of person who completed cause of death (June 23e) (Type, Print) 515 ROSENBERG AIRMOUNT 31. Date filed (Month, Day, Year) 32. Registrer Signature State JAN 191999 Registrar

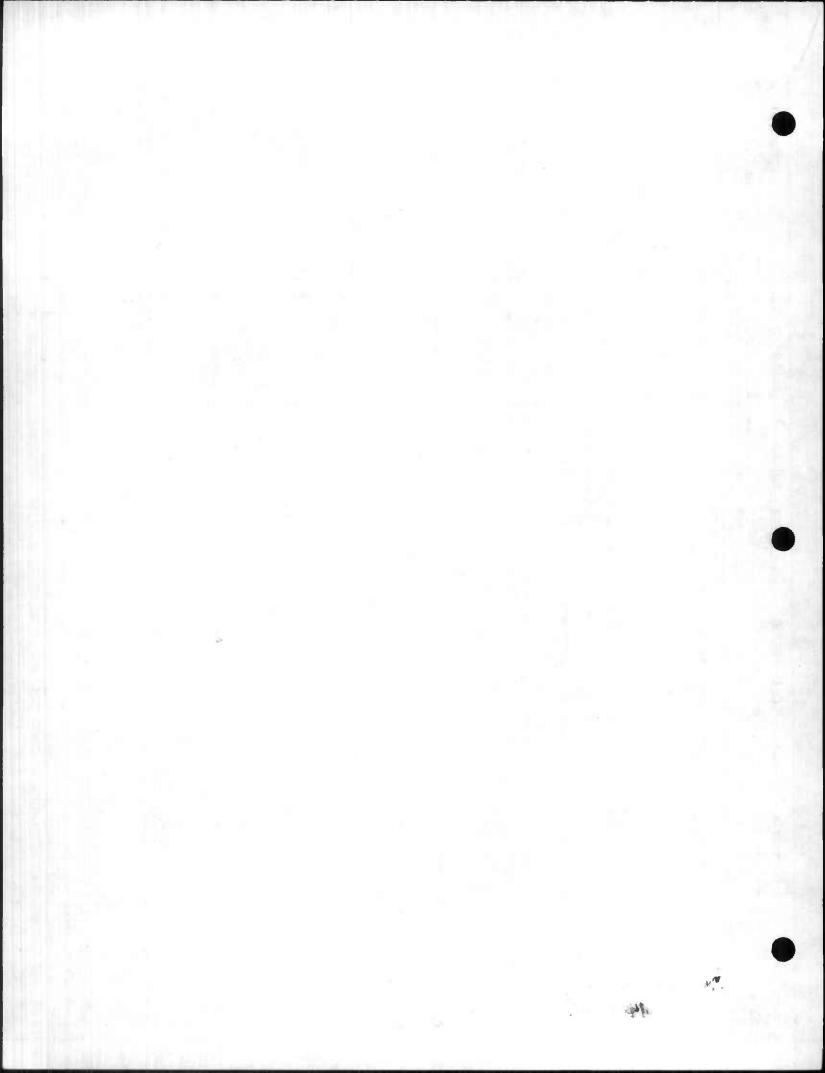


State of Maryland / Department of Health and Mental Hygiene

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Maryland H show	tor	10a. State	10b. County Howard	=		Town or Lo				I. Inside City Limits 1 ☐ Yes 2 🏋 No			
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21215-0020 d within 72 hours effer death with the Maryland glora. Fr than "natural", or flows 23s or 28s-f show . The Medical Examiner man be notified at	by	11. Merital Status  1 ☐ Never Marrie  3 ☑ Widowed		Armed Forces  1 Yes 27  If Yes, Give	Armed Forces? If Yes,			Hispanic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	o- 14. Rac Blac Specify			
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D High		17. Father's Name (	First, Middle, Las	t)				18. Mother's Na	me (First, Middle	, Maiden Sumem	ne)		
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neral rector	5. Social Security Number 6. Si 214 22 5802 1  Usual Residence of Decedent	ax ☐ M 20XF	(In yrs. last birth	day) If Under Months		Hours Min.	(Month, Da	9, 1926	9. Birthple Count Mar	nce (State or Foreigny) yland	
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ury or of	20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify)  20b. Piece of Disposition (Neme of cametery, cremetory or other pleca)  Parkwood Cemetery  20c. Location - City or Town  1/20/99  Baltimore, M										
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<b>X</b>	29b. Signature and title of cartifler	MD		290		se number		29d. Date signe JANU ARY	Month, E	Day, Year) 1999	
1			th (Item 23a) (T								



State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3 Time of Death 2. Dete of Deeth Month **Physician** 9991915 PM JAN K. WILLIAM TUCKER /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (Il not institution, give street end number) 4c. County of Death Examiner ST. AGNES HOSPITAL BALTIMORE 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 100M 2□ F Deys Yrs. 214-03-1395 Director 82 3/1/1916 MARYLAND Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD HOWARD ELLICOTT CITY 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 늄 r than "natural", or items 23s or the Medical Examinar must be r 3004 NORTH RIDGE ROAD 21043 U.S.A. Funeral Wes Decedenf Ever in U,S. Armed Forces? Was Decedenf of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Detes: WWII 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: p WHITE 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry old be filed within 72 and Mental Hygiens Elementary/Secondary (0-12) College (1-4or 5+) PRODUCTION MANAGER PAINT 17. Fathar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) WILLIAM TUCKER CLARA (GARBER) E. 19e. informent's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Health Hem 27 SUSAN M. YELINEK (DAUGHTER) 1404 SARATOGA DR. BEL AIR, MD 21014 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete parmit. Pages 1 Department of H Important: If Iter 1X Buriel 2 ☐ Cremetlon 3 ☐ Removel from Stete 4 ☐ Donetlon 5 ☐ Other (Specify) LINGANORE CEMETERY 1/22/99 UNIONVILLE, MD 22. Name end Address of Fecility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVE CATONSVILLE, MD 21228 23a. Part1. Enter the disbase, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only one cause on each line. Intervel Between Onset end Deeth **Physician** PNEUMONIA Immediete Ceusa (Finel disease or condition resulting in deeth) /Medical Examiner ANCER WITH METASTASES Examiner 2 YEARS OLON physician and the buriel-trans Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Physician/Medicai Due fo (or es e consequence of): USB 85 1 Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco uas contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ð 24b. Wera autopsy findings evelleble prior to complation of cause of daath? Completed 24e. Was an autopsy performed? 2 PNo 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yas 2 No 10 1 Inpatient 2 ER/Outpetient 3 DOA After this 27. Menner of Deeth 28e. Deta of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending Investigation ector: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 | Homicide To the Hospital within 24 hours To the Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, daeth occurred et the time, data end place, and dua to the cause(s) end menner steted. 29e. Certifier edical (Check only one) 29b. Signetura end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) MEDICAL D0053439 JAN17, 1999 OFFICER 900 CATON AVE, ST AGNES HOSPITAL, BALTIMORE, ND-21229 poeted causa of death (Itam 23a) (Type, Print) 30. Neme end addrass of parson who amatha S. Ananth

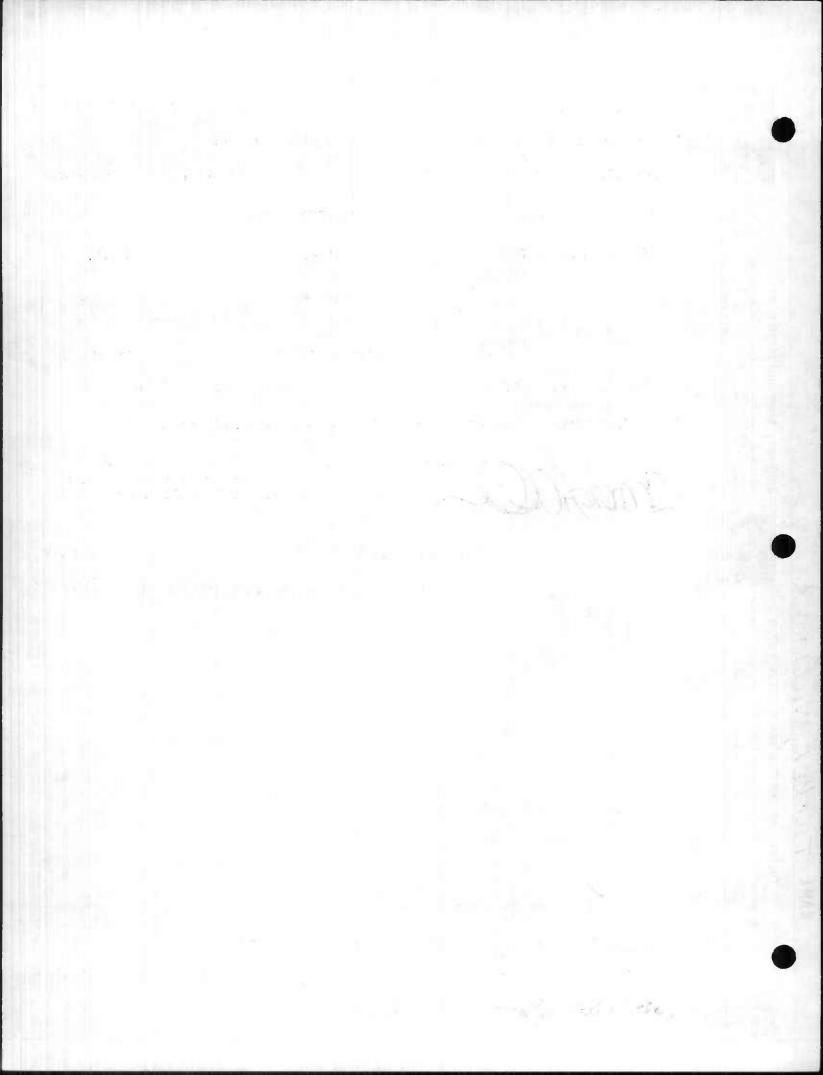
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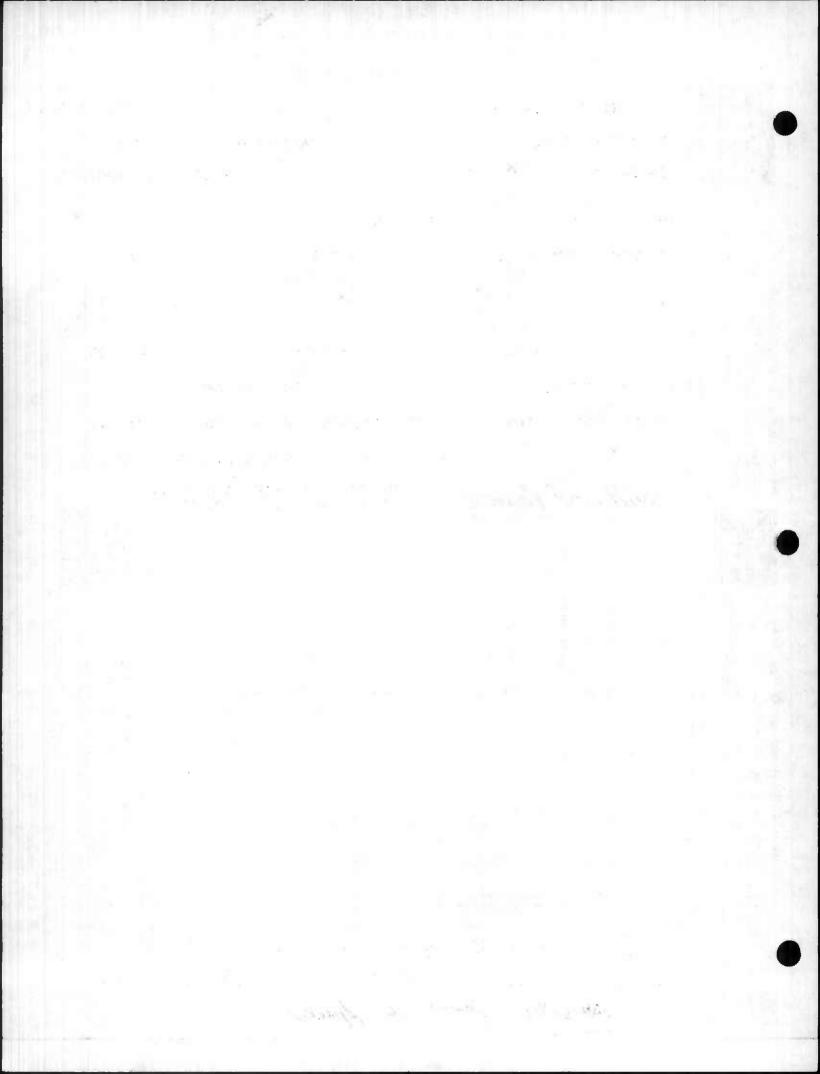
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Registrar

AME TUCKER, WILLIAM



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	-	4 ☐ Donation 5 ☐ Other (Special Service Lice		OI.		2. Nama and Addr		101/19/	99 BAL	10.,	MD.	
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١.	1	23a. Part1. Enter the disaasa, or complications that ceused tha daath. Do not antar tha mode of dying, such as cerdiac or raspiratory arrast, shock, or heert failura. List only one cause on each line.  Immediate Causa (Final disaasa or condition										
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edical		f any, leeding to immadiata ceuse. Entar Undarkying Cause (Diseasa or injury that initieted events 'asutting in death) Last	c	Dua to (c	r as a conseq	quence of):						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** TAYLOR GRACE 6 745 PM 1999 IAN /Medical 4 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 29 South Abington Avenue Baltimore Baltimore If Undar 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 25 F Months Days 219-40-7492 93 Yrs. June 8, 1905 Director Maryland Usual Residence of Decedent the Maryland 10a. State show 10b. County 10c. City, Town or Location 10d. Inside City Limits il Hygiene. other than "natural", or flems 23a or 28a-f show vent, the Maddell Examiner must be notified at Baltimore Baltimore XX Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 South Abington Avenue 21229 United States death Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) within 72 hours after ☐ Yes 2 🗓 No f Yas, Give 1 Nevar Married 2 Married 21215-0020 1 ☐ Yes 2 X No Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker home Baltimore, Maryland 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be permit. Pages 1 and 2 should be. Depenment of Health end Mental Important: If item 27 is marked of any injury or other traumatic ave. Charles Allen Fogle Lilly Mae Hippler 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Gunpowder Rd., Glen Arm, MD 21057 Dr. Charles Russell Mund/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burlal 2 ☐ Cremation 3 ☐ Ramoval from State 20c. Location - City or Town, State 5 ☐ Other (Specify 1/16/99 Brentwood, MD 4 Donation Ft. Lincoln Crematory 21. Signature of Funeral Service Lie 22. Name and Address of Facility Loudon Park Funeral Home, 3620 Wilkens Avenue Baltimore, Maryland 21229 Baltimore, Maryland 21229

Entl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediata Cause (Final a. Hypertensies arterioscleroto cardiovas culas disease disease or condition resulting In death) **Examiner** Due to (or as a consequence of): Physician/Medical Examiner certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events and-tran Due to (or as a consequence of) physician a Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of) 88 P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Did tobacco usa contribute to the cause of death? signed by t 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown The law requires that Records, þ 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy page 2 s 1 Yas 2 No 1 ☐ Yes 2 No certificate Vital 25. Was cese referred to medical axaminar? Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 PResidence 6 Other (Specify) 2 1 Yes 2 No of this 27. Manner of Deeth 1 Matural 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred s ofter death.
I Director: After to in by the funers Division 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be datermined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide Hospital To the Hospital within 24 hours of To the Funeral Completely filled 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner as stated.
2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. edical 29a. Certifier 29b, Slo and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) alloger, Ms JAN. 15, 1999 DO1786 Willema 30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print)

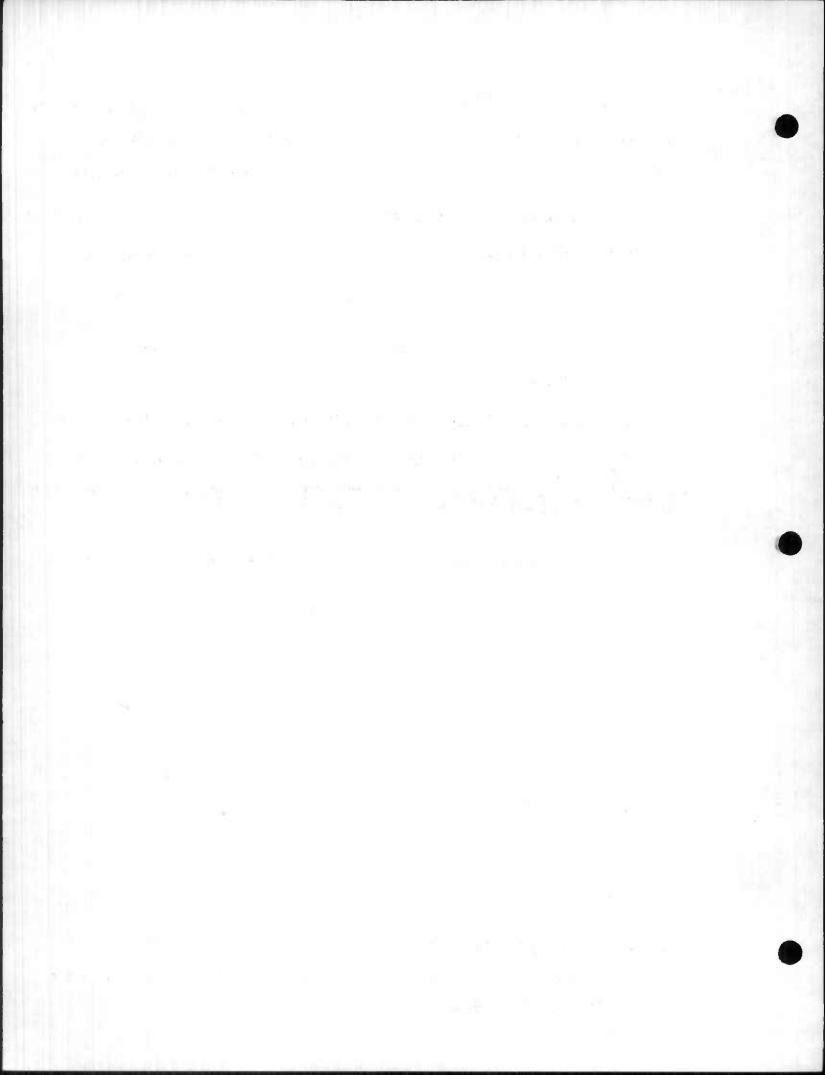
State Registrar 31. Date filed (Month, Day, Year) 1999

LAURENCE R. GALLAGER, MD

32. Registre s Signature

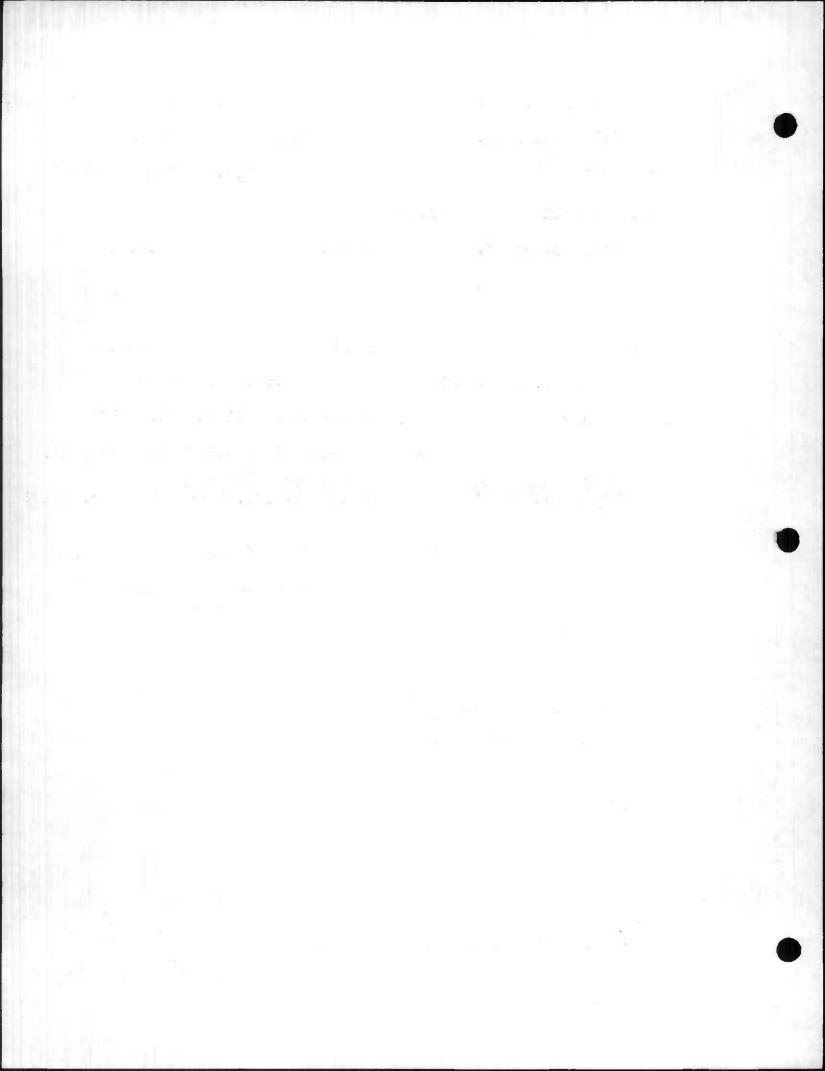
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716 MAIDENCHOICE LANE, BALTO, MD 21228



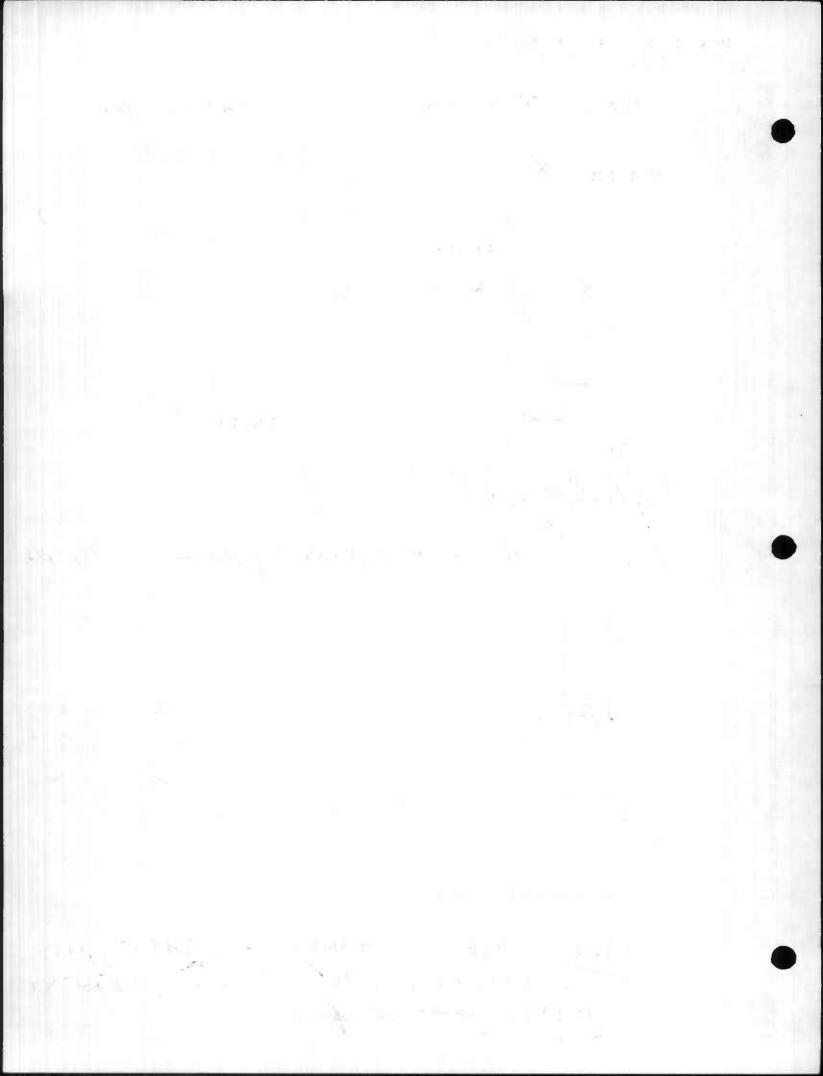
State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificate of	Death		Reg. No.	00043																		
Physiciar /Medica	_	Decedent's Nama (First, Middle, L Corinne	M. Trac	ey				2. Date of De	6, P1 1999 Y	ear 8:30 a.I																		
Examine	_	4a. Facility Nama (If not institution, giva street and numbar) 5111 Roller Rd.				4b. City, Town, or Location of Death Millers 4c. County of Death Carroll																						
Funeral Director		5. Social Security Numbar 6. 219-05-0318 Usual Rasidence of Decedent	Sex 7. Ag 1□ M 2Å F	e (In yrs. last I 84	Yrs.	If Under 1 Year Months Days	If Undar 24 Hrs Hours Min	8. Date of Bir (Month, Da Apr. 2	1, Year) 9.22, 1914	Birthplaca (State or Foreign Country) Maryland																		
a-f show diffed at	- 1	10a. State 10b. County Md. Carrol	1	10c. City, To						10d. Inside City Limits 1 ☐ Yes 2 ☐ No																		
th with the		10e. Street and Number 5111 Ro	ller Rd.		10f. Zip Coda 21102				10g. Citizen of What Country?																			
un can		11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decadent Ever in U,S. Armed Forces?  1 Yes 2 No If Yes, Give Yaar or Dates:		13. Was Decedent of if Yes, specify Cut		Hispanic Orlgin? (Specify Yas or Noan, Mexican, Puerto Rican, atc.)  Specify:			Amarican Indian, White, etc. White																		
n 72 ho "natur edical.		15. Decadent's E (Specify only highest gi	ducation ade completed)	on 16a. I		(Give kind of work done during most of wo lifa. DO NOT use ratired)		rking	16b. Kind of Busin	usiness/Industry																		
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H Se file		17. Father's Name (First, Middla, Las	•						, Maiden Sumama)																			
San Maria		Henry					Masemor																					
and 2 st earth and n 27 ls n		19a. Informant's Name/Ralationship (Type, Print)  Janice Judy  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S  5111 Roller Rd., Millers, Md. 2																										
arment of H ortant: If iten injury or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Special Content of the Content		ceme	ary, crei	osition (Name of matory or other pla IS Ceme1		Date n.18,1	20c. Location - City 999 Line	y or Town, State boro, Md.																		
Desmit. Depart Import any inj poss.		21. Signature of Fundant Service Lice	blacett	Iha daath D	3	Name and Addr Eckhard 3296 Cha	armil D	r., Mar	chester	, Md. 21102																		
Physician /Medical Examiner		23a. Part1. Ehier the chease, or conshock, or heart finitire. List only Immediate Causa (Final disease or condition rasulting in death)								Interval Between Onset and Death																		
à	5	, , , , , , , , , , , , , , , , , , , ,		Dua to (or as	consec	quence of):				Seur																		
	cian/Med	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Some arter duein as a consequence of):					Just																				
ing a a a		that initiated events resulting in death) Last	d	Due to (or as a	conseq	uenca of):																						
the attendii		by	DA.	py	py	DA.	D	Dy	o ·	p	o ·	Sicia	SICIA	Sicial	SICIO	SICIA	olc la	Sicial	E SICIOI	Part II. Other significant conditions	contributing to death bu	ut not resulting	in the u	nderlying cause gi	ven in Part I.	23b. Dld	tobacco use contril	buta to the cause of death?
5 80												Cerebra	Noscul	ara	lu	reare		10	Yes 2 No 3	□ Probably 4 □ Unknown								
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cata ha								10	Yes 2 No	1 □ Yes 2 □ No																		
Physician: The this certificate ral director, page Co.: To Be Co.	2	25. Was case rafarrad to medical examinar?  1 ☐ Yes	Hospital:	م ما		Oti Doub Oti	nar:	ath (Check only																				
or Attending Physics death.  Director: After this is by the funeral diffication: Tentification:	ation: To										27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatie 28a. Date of Injur (Month, Day		Time of Injury	28c. Inju	4 LI Nursing F		denca 8 Othar (	Specify)									
or At		3 Sulcide 6 Could not I datarmined	28e. Placa of Injubuilding, etc	ry - At home, : (Specify)	nome, farm, street, factory, office  28f. Location (Street and Nu City or Town, State)					or Rural Route Number,																		
To the Hospital within 24 hours of the Funeral I completely filled	200	29a. Certifier 1 ☐ CartifyIng Pl (Check only one) 2 ☐ Medical Exa	nyaiclan: To the best of minar: On the basis of and manner sta	examination a	ge, death ind/or in	n occurrad at tha ti vasfigation, in my o	ma, data and place opinion, death occu	a, and due to the urred at the time,	causa(s) and manne date and place, and	er as stated. dua to tha causa(s)																		
withir comp		29b. Signature and title of certifiar	Slan	h	N	29c. Licens	5e number 5 / 9/5	5	29d. Date staned (N	rongh, Day, Years																		
4		30. Nama and address of person who	CAPM	eath (Nem 23a	) (Type,	16921	youle	e Rd	Kunhli	to Nat 2111																		
State Registrar	4	31. Date filad (Month, DAN ar)	1999 <sup>32. Registr</sup>	's Signatura		6. 6				,																		



Items:5,10e,19b per F.H G-768 2/2/99 reb Item#17,19a per FH G767 1/21/99 EW State of Maryland / Department of Health and Mental Hygiene J Item 12 Per FH FilmG767 1-19-99 rja Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death 10:00 AM Peter **Physician** IRABER 15 AN /Medical 4b. City, Town, or Los 4a Facility Name (If not Institution, giva street and number) tion of Death 4c. County of Death Examiner Columbia Howard 11674 Little Patuxent Parkway If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) June 30, 1921 7. Age (in yrs. last birthday). 5. Social Sacurity Number Sex 1 M 2 □ F Birthplece (State or Foreign Country) **Funeral** Months Days Hours 176-44-2621 176-14-2621 Yrs. Pennsylvania **Director** Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits Item 27 le marked other than "naturel", or items 23a or 28a-f show other traumetic event, the Medical Examinar must be notified at 1 Yes 2 No Maryland Howard Columbia Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21044 U.S.A. 11674 Little Patuxent Parkway Apt. #103 pemit. Pages 1 and 2 should be filed within 72 hours effer death v Department of Health and Mental Hygiena. Important: If item 27 is marked other than "naturel", or items 23a eny Injury or other treumetic event, the Medical Examiner manal once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? X Dives 2240 194 If Yes, Give 194 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien. Black, White, etc. 1 Nevar Married 2 Married 1942 1945 1□Yes 2XNo White Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorcad 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grede completed) Federal Highway Collega (1-4or 5+) Elementary/Secondary (0-12) Engineer 4 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Sumeme) George Gerege-Trbovich Ruby Birkovich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Steta, Zip Code) 11674 Little Patuxent Parkway Columbia, Maryland 21044 Ms. Florence T. Taber Traber Wife 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burjan Cremation 3 | Removal from State 01/16/99 Baltimore, MD Metro Crematory 5 Othar (Specify) 4 Donation 22. Nama and Addrass of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Service Licenson 1000535 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Hodgkin's Lyyhouse /Medical Immediata Cause (Final disaase or condition rasuling in death) Examiner Examiner thet the death certificate be executed attanding physician end for use as the bunal-tran Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 80 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes No 3 Probably 4 Unknown Aq 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed has 1 Yes 2 No 1 Yes 2 No certificate or Attending Physician: 25. Was case referred to medical examiner? Be 28. Place of Death (Chack only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 10 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Yaar) funeral 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: Affer 1 Natural 5 Pending aftar deeth. 1 ☐ Yas 2 ☐ No Investigation 2 Accident 6 Could not be datarmined 3 ☐ Sulcide 28f. Location (Streat end Number or Rurel Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledga, daath occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and manner stated. Medical 29a. Cartifiar (Check only one) To the To the To the P 29d. Date signed (Month, Day, Year) 29c. Licanse number 29b. Signature and title of cartifiar 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 1k way, Columbia Little latu 11065 31. Date filed (Month, Dey, Year) 32. Registraris Signature State JAN 191999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Data of Death 3. Time of Death Month **Physician** 99 JAN 2145 DO CAT rand 15 /Medical 4e. Facility Neme (If not institution, give street end number, 4b. Cltv. Town, or Location of Deeth 4c. County of Deeth Examiner al university Mary more land If Under 24 Hrs. If Under 1 Yeer 5. Sociel Security Number 7. ge (In yrs. lest birthdey) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Deys 1 M M 2□ F Months Hours Min. Yrs. 215-50-1983 49 Director Nov 12 1949 MD. Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f shot the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Carroll New Windsor MD. 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2306 Overbrook Drive 21776 U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11 Merital Status Bleck, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white P 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygians. Elementery/Secondery (0-12) College (1-4or 5+) financial advisor financing 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked of Laumann Robert W. Uhland, Sr. Mary 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 7210 Kennebunk Rd., Baltimore, Md. 21207 Robert W. Uhland, Sr. Father 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1/18/99 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore/Washington Crem. Laurel, Md. 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tellure. List only one cause on each line. Approximata Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final monoma disease or condition rasulting in deeth) Examiner Examiner that the death certificate be executed attending physician and for use as the burial-tran Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or es a consequence of) Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of): been signed by the a should be detached t Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 Vunknown 1 Yes 2 No þ 24b. Ware autopsy findings evellabla prior to 24e. Wes an autopsy performed? Completed completion of cause of death? has 2/2 No 1 ☐ Yes 20 No 1 Yea this certificate Division of Vital Be 25. Was case reterred to medical 28. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA filled in by the funeral 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Dascribe how Injury occurred Certification: Affer 1 Neturel 5 Pending Investigation death. 1 Yes 2 No Hospital or Attending 24 hours after death
 Funeral Director: A 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, tectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) and manner as steted.

2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) To the Hosp within 24 hou To the Fune completely fil cal 29a. Certifier

end manner steted.

Univ

A. Registrer's Signature

Mun voya NVD 30. Neme and addrass of person who complated cause of deeth (Item 23e) (Type, Print)

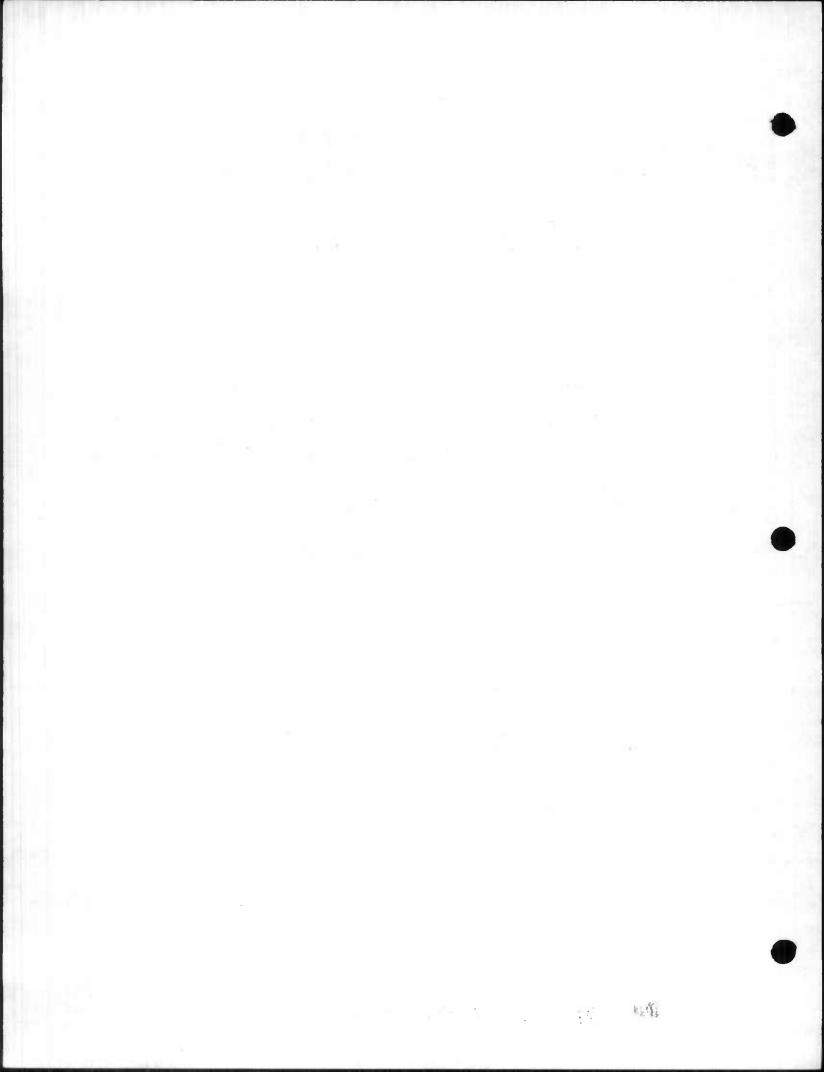
State Registrar 29b. Signeture end title of certifier

JAN 1 9 1999

31. Dete tiled (Worth, Dey, Year)

**DHMH 16 Rev 6/95** 

29c. License number 29d. Dete signed (Month, Dey, Year)



99-0224-043 cm Jereny Weaver

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00846

3. Time of Death

6:30 P.M.

WV

10d. Inside City Limits

MYes 2 No

Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** 14, 1999 Jeremy Todd Weaver January /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Interstate 70 at the 21 Mile Marker Clearspring Washington If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1₩ M 2□ F Months Hours 232-13-7989 Director 21 June 22, 1977 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location appa / Upshur WV Buckhannon Directo 288-1 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? \*natural", or flams 23s or must be 26201 84 South Florida Street United States Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Wes Decedent Ever in U.S. Armed Forces? Bleck, White, etc. afte 1 ☐ Yes ★No 1 Never Married 2 ☐ Married Maryland 21215-0020 1 Yes XX No Specify: Specify: à White 72 hours 3 Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Auto Mall Driver 12 0 18. Mother's Neme (First, Middle, Meiden Surname) 17. Father's Nema (First, Middle, Last) 1 and 2 should be fill tealth and Mental H im 27 is marked off Be Jerry Franklin Weaver Terecia Annette Tolliver 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Cepartment of Health as important: if hem 27 is: any injury or Jerry Franklin Weaver / Father 1003 Clifton Road, Bethel Park PA 15102 altimore, Pages 1 g 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Upshur County memorial Cemetery Jan. 18, 1999 Ruckhannon, W 21. Signature of Funeral Senice Licensee 22. Neme end Address of Fecility Victor P. Doda, Jr. Charles L. Stevens Funeral Home, 1501 E. Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause un mach line. **Physician** Immediete Ceuse (Final disease or condition resulting in deeth) /Medical onwill Examiner Due to (or as a consequence of): Examine burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest and Due to (or as a consequence of) physician s the buriel Box 68760. Physician/Medical Due to (or as e consequence of): 980

that the death certificate be ò Records, P.O. 96 signed by I by Completed Deen of Vital 8 Certification: To this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After ti completely filled in by the funeral Division

Pe

rt II.	Other	algnificant	t conditions	contributing	to death b	ut not r	esulting in	the underly	ing cause	given in Pert	I.

23b. Did tobacco use contribute to the cause of death? 42 Unknown 1 Yea 2 No 3 Probably

24a. Wes an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

Approximete Intervat Between Onset and Deeth

1 X Yes

1 Yes 2□ No

25. Wes case referred to medical	26. Place of Deeth (Check only one)										
examiner? 1 XYes 2 No	Hospitel: 1   Inpatient	2 ER/Outpatient	3 DOA	Other: 4 Nursi	ing Home	5 Residence	6 DOther (Specify)	at	scene		
27. Menner of Death	28a. Dete of Injury (Month, Dev Yea	28b. Time of	28c.	Injury et Work?	28d	. Describe how in	jury occurred		120		

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 1 Yes 2 No Investigetion 530 2 Accident 6 Could not be 3 ☐ Suicide 4 Homicide

Subject dive of black 281. Location (Street and Number or Aural Route Number, City or Town, Stete) Introduct 70 0011 men Chinopping May (and object

January 15, 1999

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/er investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted. 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature end title of certifies

O.C.M.E.

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

MIKIM

111 Penn Street, Baltimore, Maryland 21201

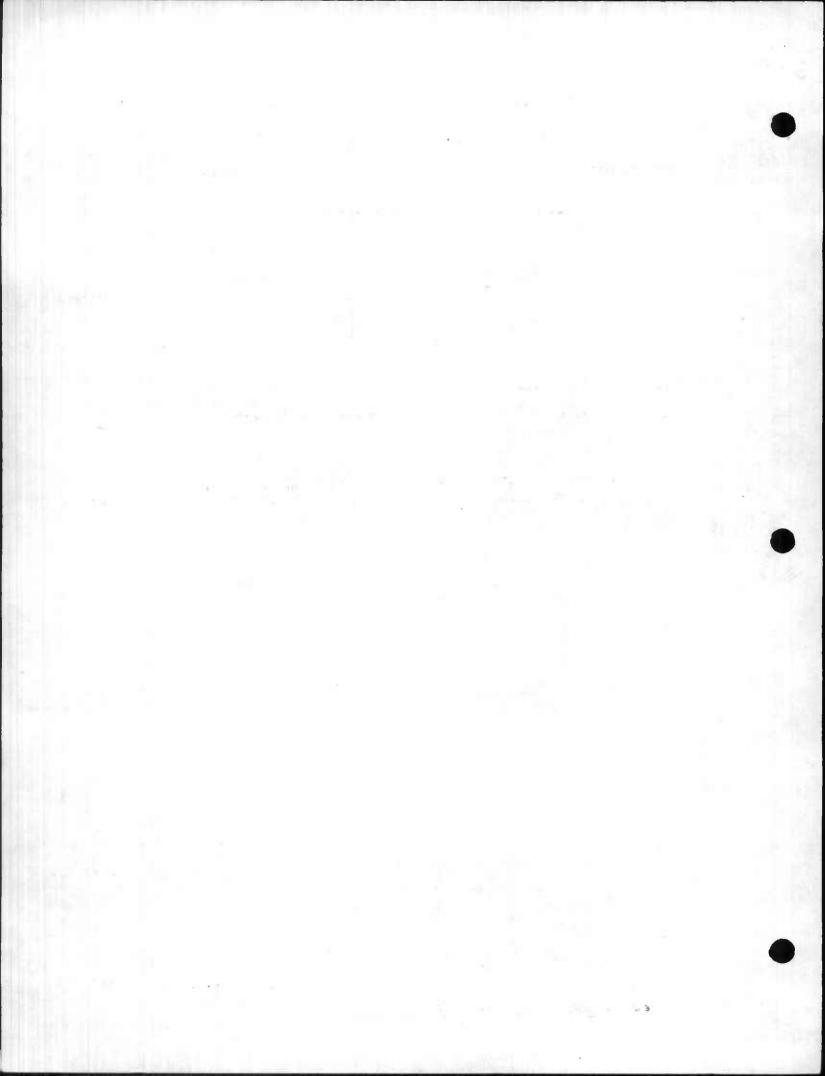
State Registrar

Medical

THEODIRE

32. Registrer's Signature parks

No odway

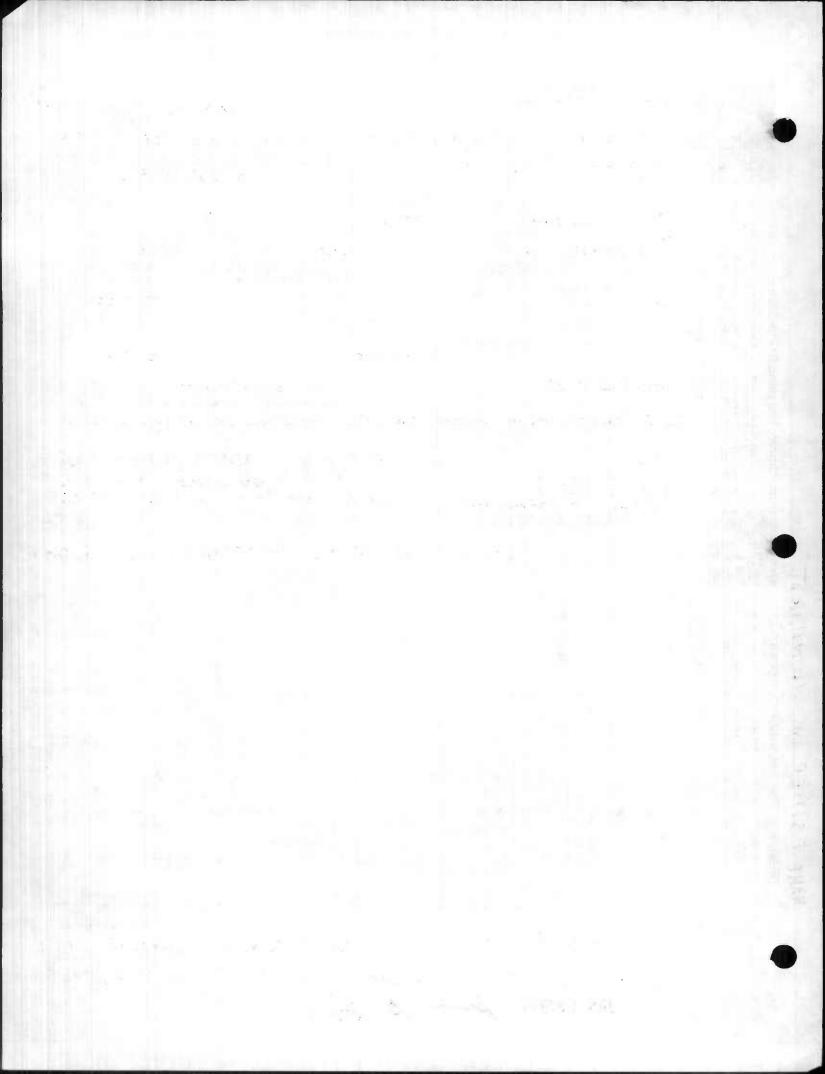


State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death

Reg. No.

	Certificate of Death	Re	eg. No.	00047							
Physician /Medical	1. Decedent's Neme (First, Middle, Last) Esther W. Weinhardt	2. Date of Deet Month	Month Day Yeer								
Examiner	4e Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  37 - AGNES HEALTH CARE BALTIMORE BALTIMORE										
Funeral Director	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	8. Dete of Birth (Month, Dey, Nov. 13		). Birthplace (State or Foreign Country)  MD							
PG &	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits							
the Marylar 28a-f show nout ed at		1 ☐ Yes 2 ☐ No									
with the Manager of the mouth	10e. Street and Number         10f. Zip Code         10g. Citizen of Whet Country?           604 Oak Hill Road         21228         U.S.A.										
72 hours after death with the Maryland naturel; or Items 23a or 28a-1 show area Examiner must be noured at ested by Funeral Director	11. Meritel Status  12. Wes Decedent Ever in U,S. Armed Forces?  1 \( \text{Never Married} \) 2 \( \text{Married} \) Married  13. Wes Decedent of Hispanic Origin? (Sp. If Yes, specify Cuben, Mexican, Puerton It Yes, Give Year or Dates:  13. Wes Decedent of Hispanic Origin? (Sp. If Yes, specify Cuben, Mexican, Puerton It Yes, Specify: \( \text{Vest} \) 1 \( \text{Ves} \) 2 \( \text{No} \) No Specify:	pecify Yes or No- Dican, etc.)		American Indien, White, etc.							
be filed within 72 hot tel Hygiene. d other than "nature event, in Medial		cina	16b. Kind of Busin	ness/industry							
r than r	(Specify only highest grede completed)  (Give kind of work done during most of work life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	,9									
other the	2 Teacher  17. Fether's Name (First, Middle, Last)  18. Mother's Nem	Education me (First, Middle, Maiden Surneme)									
in and Mentel Hyg 7 Is marked other traumatic event, To Be C	John Paul Wolff  Celest	te Gregory									
To	19e. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru		-	lete, Zip Code)							
trau	Carol Weinhardt-Kemble Daughter 238 Rolling Brook Way										
f Hea ttan other	20a. Method of Disposition 20b. Place of Disposition (Neme of		20c. Location - Ci								
nt: If	1 1 3 HIMA 2 I I FEMATION 3 I HEMOVALITOM STATE	1/16/99	Baltimor	re, Maryland							
Doparment of Health at Important: If item 27 is any injury or other training to the contract of the contract o	21. Signature of Funeral Service Licansee  22. Name and Address of Facility  Witzke Funeral Homes, Inc.  1630 Edmondson Avenue, Catonsville, MD 21228  23e. Pentl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between										
death certificate be executed the entire of the second of	Immediate Ceuse (Final disease or condition resulting in death)  INTIRA CRANIAL HEMORRHUE 5 DAYS  Due to (or es a consequence of):										
ng physician s es the buna <b>Wedical E</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last  Due to (or es a consequenca of):  Due to (or es a consequenca of):  Due to (or es a consequenca of):										
requires thet the death ce ween signed by the attendi hould be deteched for use teed by Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	23b. Did tobacco use contribute to the causa of death?								
ed by the deteched		1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown									
een signi hould be		24a. Wes e perlon	on autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?							
page 2		1 □ Ye	es 2 No	1 ☐ Yes 2 ☐ No							
certificate hes b rector, page 2 s	25. Wes case referred to medical 26. Plece of Death (Check only one)										
Physician: this certific ral director,	examiner? 1 ☐ Yes 2 IX No  Hospital: 1 IX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  Other: 4 ☐ Nursing H	ome 5 Reside									
leath. tor: After the fune	27. Menner of Death  1 Naturel 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Dey Year)  28b. Time of Injury M  28b. Time of Injury M  28c. Injury at Work?  1 Yes 2 No										
pital or At burs efter of eral Direct filled in by	4 ☐ Homilcide determined determined building, etc. (Specify)	3 ☐ Suicide 4 ☐ Homloide  Could not be determined  28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, Stete)									
Hospi 14 hours Funer tely fil	29a. Certifier (Check only one)  1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete and place conditions and/or investigation, in my opinion, death occurred et the time, dete and place conditions and/or investigation, in my opinion, death occurred et the time, dete and place conditions and/or investigation, in my opinion, death occurred et the time, dete and place conditions and/or investigation, in my opinion, death occurred et the time, dete and place conditions and/or investigation.										
Within 2 To the comple	29b. Signature and title organization , 29c. License number			(Month, Dey, Year)							
	M.D. #P 126	00	JAN.	13.1999.							
62	30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)  SHA1-1D RAT-1Q, ST. AGNES HOSP. 9	OU CATO	ON AV	E, BALTIMOR							
State Registrar	31. Date filed (Month, AN Year) 9 1999 32. Registrer's Signature										



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Whitehead 12216 01 16/1999 11:49 P.M. /Medical 4e. Fecility Neme (If not Institution, give street end number 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Bowleys LANE BALTIMURE
If Under 1 Year If Under 24 Hrs. 8, Date of Bir 507 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Yaer) 10 /13 / 19 38 Birthplece (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days 1□M 2▼F Months Yrs. Director 217-78-0098 VIRGINA Usual Residence of Dacedent the Meryland 10e. State 10b. County 10c. City, Town or Location 10d. Inaida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examiner must be notified at 1 Yas 2□No Director MARY AND 10e. Street and Number BALTIMORE 10g. Citizan of What Country? death with U.S.A. 5507 Bowleys 21206 LANE 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 (MNo If Yes, Giva Yeer or Detes: 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status permit. Pages 1 end 2 should be filed within 72 hours after a Department of Health and Mentel Hygiena. Important: If Item 21 is merked other than "natural", or free any Injury or other traumatic event 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorcad Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Medica) NURSE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE Ribles AddIE (UNKNOWN) 19a. Informent's Name/Reletionship (Type, Priht) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Jeanette PRIDGEN/DAUGHTER HAISTEAD RD. BALTIMORE, MARY AND ZIZ34

tion (Name of the property)

Dete 20c. Location - City of Town, Steta 1126 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 1 Burial 2 Cremetion 3 Remove from Stete 21 99 LANdsdowne, MARY AND 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 200 22. Name end Address of Fecility THE 22. Name and Address of Facility The Deprice C. Junes

Funeral Home: 4610 Park Heichts Ave.

134-17 Mure Pand Address of Facility The Deprice C. Junes

Funeral Home: 4610 Park Heichts Ave.

134-17 Mure Pand Address of Facility The Deprice C. Junes

Funeral Home: 4610 Park Heichts Ave.

134-17 Mure Pand Address of Facility The Deprice C. Junes

Funeral Home: 4610 Park Heichts Ave.

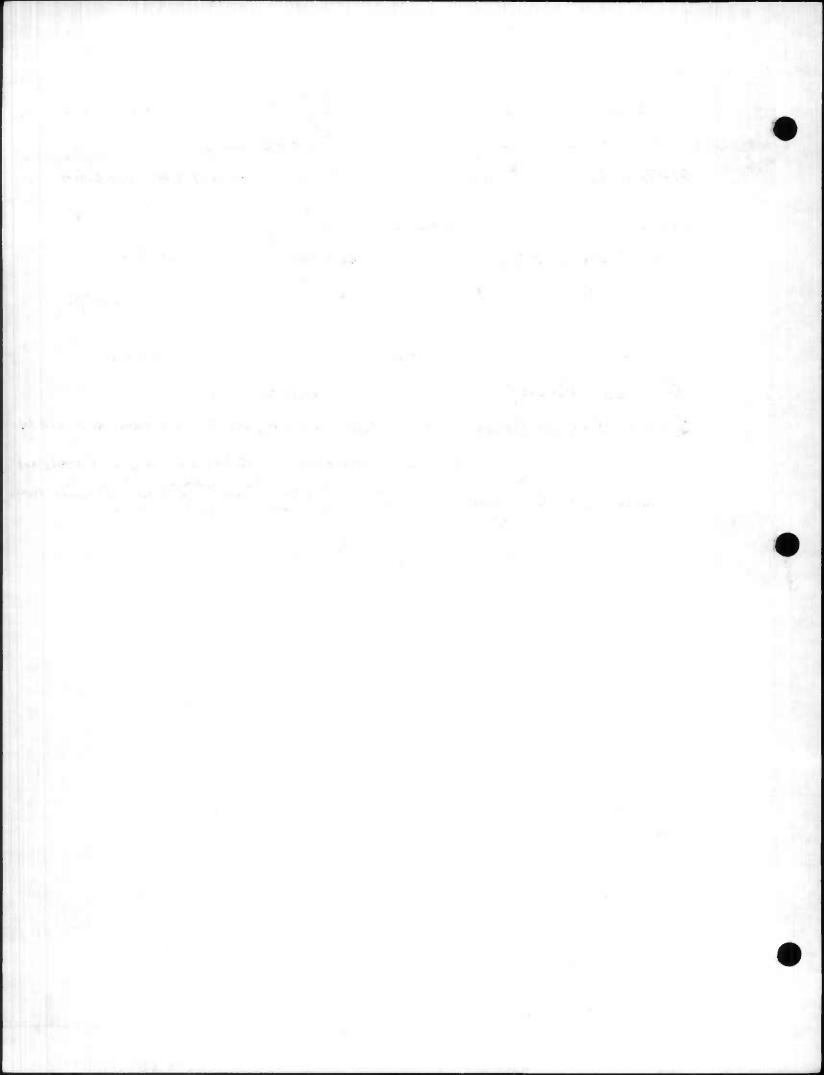
23a. Part1. Enter the disease, or compilections that a usuad the death. Do not anter the mode of dying, such as cardiac of respiratory arrast,

Approximate Approximete Intervei Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel Esophasal · Metastatic 4 MOATHS disaese or condition resulting in death) Examiner Due to (or as a consequence of): burial-transit and Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or as e consequenca of): physician s the burial P.O. Box 68760, Physician/Medical Due to (or as e consequenca of): 189 98 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 0s 2 No 3 Probably 4 Unknown Records, by 24b. Ware autopsy findings aveliable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed certificate Division of Vital To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4□ Nursing Home 5 Sesidenca 6 □ Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Naturei 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 038409 118/99 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Baltone, Ad 21224 4940 Eister Ne WILLIAM 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture State JAN 1 9 1999 Registrar

DHMH 16 Rev 6/95

PER A A A A A A A A A A A A A



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month Disniewsk Jan /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street end number) **Examiner** BowiE If Under 24 Hrs. Hours Min. If Under 1 Year 5. Sociel Security Number Birthplace (State or Foreign County) 7. Age (In yrs. last birthday) **Funeral** 213-01-4467 10 M 20 F Yrs. Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumstic event, the Medical Examiner must be notified at BALTIMORE 1 Yes 2 No Director 10e. Street end Number 10g. Citizen of Whet Country? ò "natural", or items 23a 11.5.A Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 4. Rece - American Indien, Bleck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours effer a Department of Health and Mental Hygiene. I important: If Item 27 is merked other than "natural", or item any injury or other treumstic event 1 Never Married 2 Married Baltimore, Maryland 21215-0020 py 3 Widowed 4 ☐ Divorced WHITE Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) FACTORY WORK ABOREL 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) WISNIEWSKI MAKVANN BALCEAK 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 13233 D'ANGELO DR. BOWIE, MD. 20 720

20c. Location - City or Town, State STRZEGOWSKi 20a. Method of Disposition

1 ABurial 2 Cremetion 3 R

1 Donetion 5 Other (Specify) Burial 2 Cremetion 3 Removel from State 614 ROSARY BALTO. CO. MD. 21. Signeture of Funeral Service Licenses 2829 HUDSON ST BALTO. MD. 21224 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete thervel Between Onset and Deeth **Physician** Atherosclerotic Heart Disease /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Examiner physician end the burial-transit Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting In death) Lest P.O. Box 68760, Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 20 No 3 Probably 4 Unknown 1 Yee Division of Vital Records, p 24b. Were eutopsy findings evallable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifice 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menper of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Matural 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) and menner as steted.
2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. 29e. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 2010 completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Dey, Year) DWIE State Registrar

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) D. WINNS 03:34 KICKIE January 4c. County of Deeth 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Bay View Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 10xM 20 F Yrs. 217-70-0106 42 MD Feb. 5, 1956 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2□ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5609 St. Clair Lane 21206 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien 11. Maritei Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Self-employed/carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Herman Winns Sr. Dorothy Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Essie Mae Smith/girlfriend 5609 St. Clair Lane, Balto, Md 21206 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/20/99 Moncks Corner, SC. Mitten Land Cemetery 4 Donation 5 Other (Specify) 22. Neme and Address of Fecility Sterling-Ashton-Schwab Funeral Home. Inc 736 Edmondson Ave, Balto, Md. 21228 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardido or respiretory errest, the art failure. Ust only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) 12 hours sebsis (or as a consequence of). Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Alcohol withdraw 24e. Wes an eutopsy performed?

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Directo

Funeral

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Completed

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**Funeral** 

Director

r than "natural", or items 23s or the Medical Examiner must be

Baltimore, Maryland 21215-0020

filed within 72

Hygiene.

permit. Pages 1 and 2 should be file.
Department of Health and Mantal Hy
Important: If them 27 is transfed oth
any injury or other traumatic event
dence.

Examiner Physician/Medical 98 by Completed

physicianand signed by the a has certificate ha Be 10 Certification:

The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifical eleity filled in by the funeral director; To the Hosp within 24 hor To the Fune completely fi

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28h Time of 28d Describe how injury occurred 28c. tnjury et Work? 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only

29b. Signature and title of certifier PHYSICIAN 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) VICTORIA PORTER

4940 EASTERN

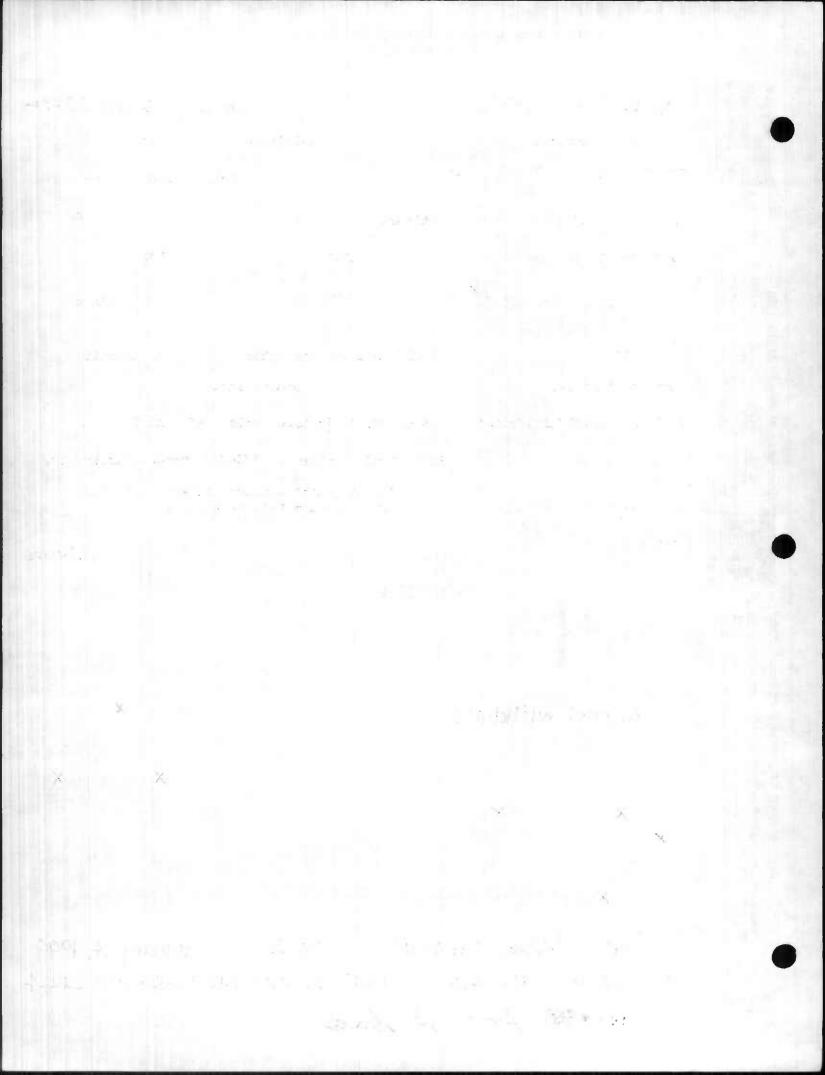
BALTIMORE MARYLAND

31. Date filed (Month, Dey, Year) Registrar

edicai

JAN 1 9 1999

32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month 1155 PM CARL 1999 WALZOG JAN 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death LOCH RAVEN GENESIS NURSING BALTIMORE BALTIMORE CO HOME Hours Min. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F Deys 214-05-3170 86 Yrs. MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits CAROLL CO 1 Yes 2 No I NESTMINISTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? POOLE RD 21157 410 U.S. A. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, 2 Voo If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WhITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OSTAL WORKER NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) FREDERICK, J. LUALZOC ROSE MARIE JE IFFERTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MR CARL .M. COLVIN BALTO. MD GLEN OAK AVE 6002 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 1/19/99 BALTI. MD 22. Name and Address of Facility Miller Funeral Home CHTD. 21. Signeture of Funeral Service Licensee Miller BALTE. MD 21334 Harford RB 7527 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such es cardiec or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset end Death ibillation Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence ot): Due to (or as a consequence ot): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings eveileble prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2 Wo 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Wursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Box 68760, P.O. à been signed I should be det Records, pege 2 Division of Vital the Hospital or Attending Physician: funeral director, After this s efter death.

Examiner by Medical Certification: To filled in by

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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items 23a

"natural", or Items 23c

should be filed within 72 hours efter and Mentel Hygiene.
marked other than "natural", or itellumetic event, it is Medical Examinations.

permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked orth any linjury or other traumatic event ans.

Physician

/Medical

Examiner

21215-0020

Baltimore, Maryland

Director

Funeral

by

Completed

Physician/Medicai Completed

25. Wes case referred to medical examiner? 1 Yes 2 No

> 5 Pending investigation Natural 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

BALTO

28f. Location (Street and Number or Rural Route Number, City or Town, State) LECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of milifier

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and arress of person who completed cause of death (Item 23e) (Type, Print) 6331

wong Vu GUYEN 31. Date filed (Month, Day, Year)

**JAN 19** 

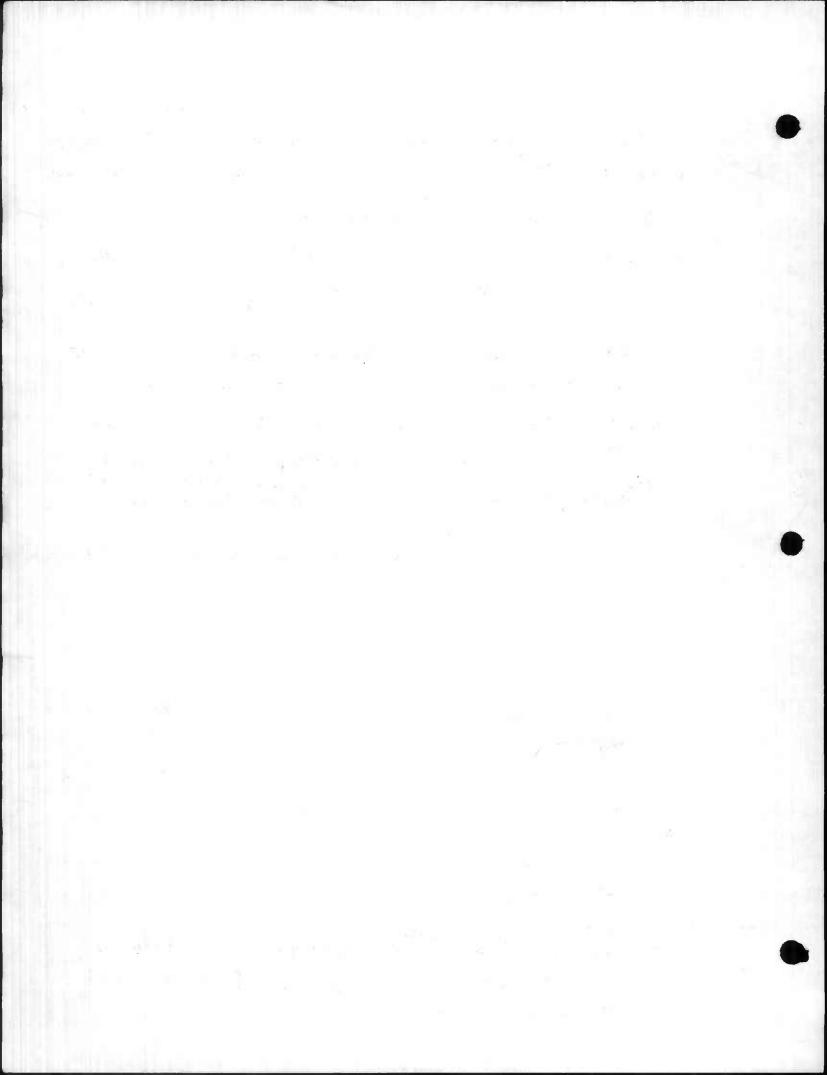
none

32. Registrar's Signature

State Registrar

**DHMH 16 Rav 6/95** 

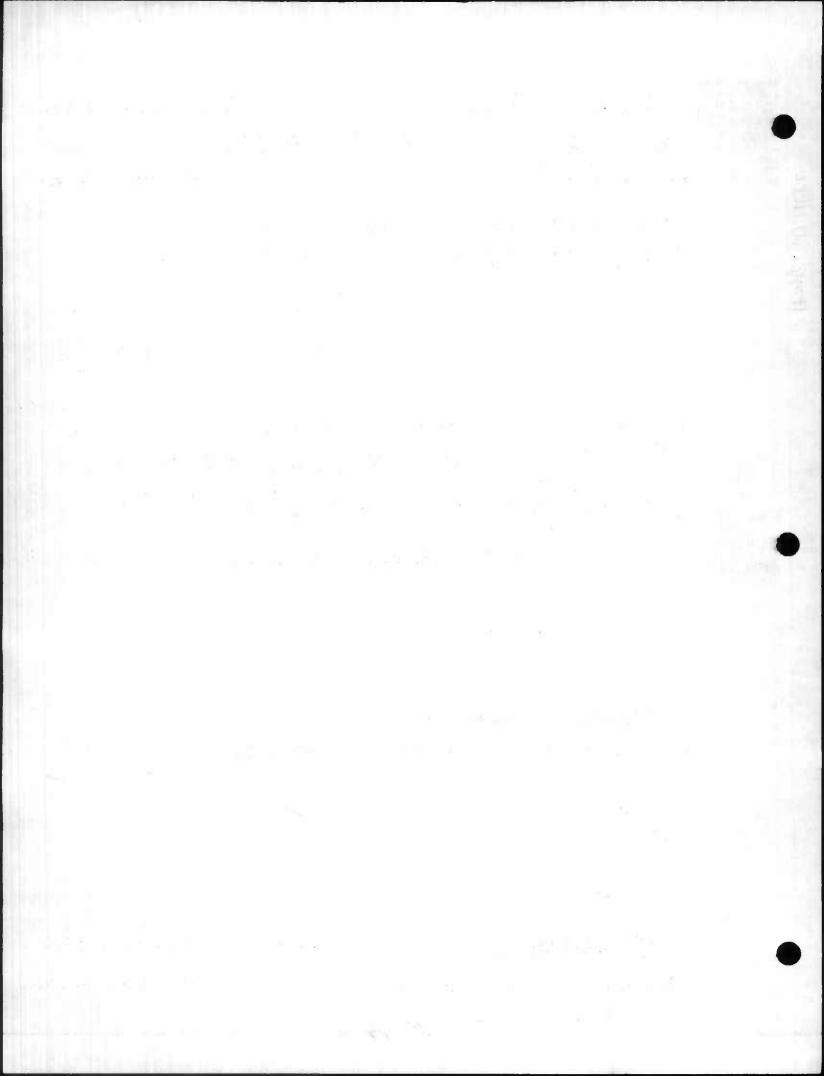
To the Hospital of within 24 hours of To the Funeral D completely filled it



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Eunvary 14 6:44 am /Medical 4b. City, Town, or Location of Deeth Neme (If not Institution, give street end number) 4c. Coupty of Deeth Examiner 7. Age (In yrs. **Funeral** Deys 12 M 2 F Hours Director 10c. City, Town or Location show 10d. fnside City Limits 1 Yes 2 No Director 238-1 10e. Street end Numbe 10g. Citizen of What Country? 6 , or Items 23a Funerai Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Wes Decedent Ever in U.S. 11. Maritel Status American Indien Bleck, White, etc. 1 Never Married 2 Mamied Yes 2 No 1 Yes 2 No altimore, Maryland 21215-0020 Specify by 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Be Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) mportant: If Item 27 is marked other 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Health and Mental 19e. Informent's Neme/Reletionship (Type, Print) 2/201 1221E 20e. Method of Disposition 1 Burial 2 Cremetion 4 Donetion 5 Other (Specify) 21. Signeture of Funerel se, or complications that caused the deeth. Do not e 22d. Pert1. Enter the disees shock, or heert feilure. Approximete Intervel Between Onset end Deeth Physician /Medical Immediete Ceuse (Finel THROMBOSIS Comontho disease or condition resulting in deeth) Examiner Physician/Medical Examiner hysician end the buriel-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Due to (or es e consequence of) P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 3 Probably 4 Onknown ATRIAL FIBRILLATION signed I Records, Be Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy INSULIN REQUIRING DIABETES MELLITUS 1 Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this cartifict completely filled in by the funeral director, to 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of fnjury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Yes 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

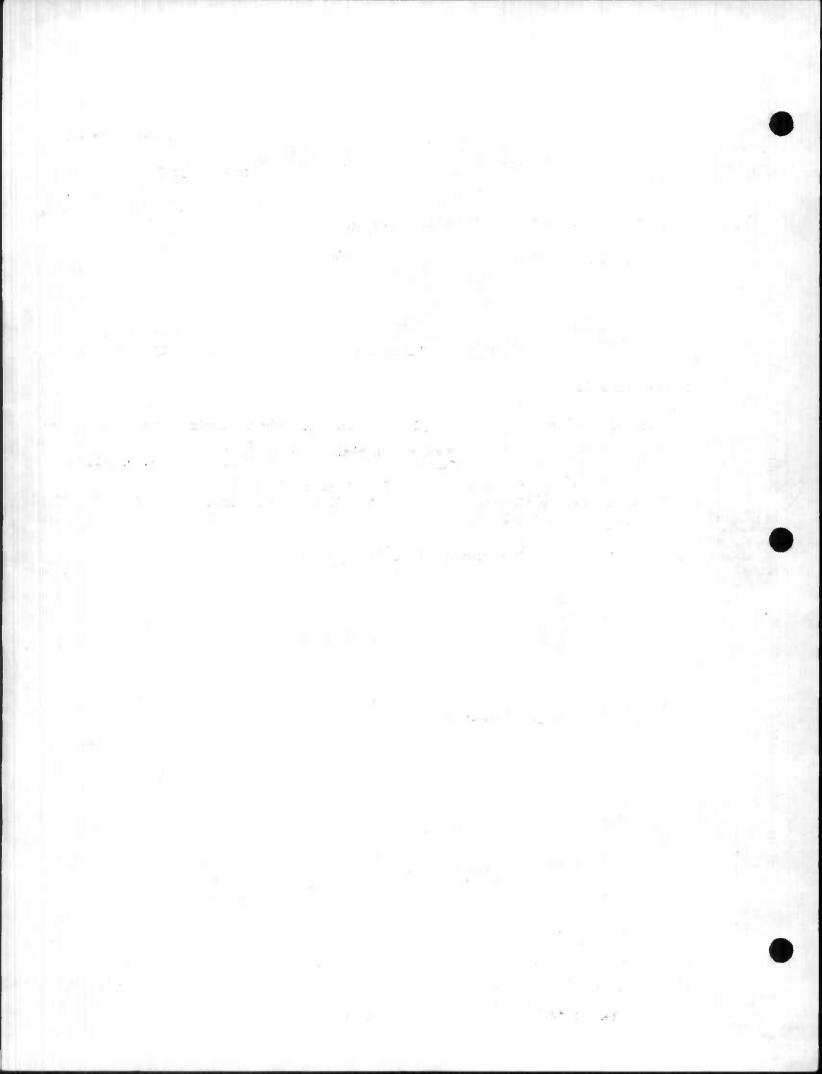
2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner stated. 29a. Certifier Medicai 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number January 16, 1999 1445931 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Park Heights Avenue Baltimore, MD 2208 7220 Leburah 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JAN 191999 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 08:24 AM Ivia Weiser LINUALY 16 /Medical 4a Facility Name (II not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Moutgomer Montgomery General 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Antholice (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 🖾 F Yrs. Director July 9, 1917 81 New York 10a. Stete 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f ahow the Madical Examiner must be notified at 10d. Inside City Limits 1 Yes 2000 Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 3500 Forest Edge Drive Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritei Stetus permit. Pages 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or her any injury or other traumatic event, the Medical Exertinations. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Married 2☑ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Johns Hopkins College (1-4or 5+) 5+ Elementery/Secondery (0-12) Applied Physics Lab. Librarian 18. Mother's Name (First, Middle, Maiden Surname) UKN 17. Father's Neme (First, Middle, Last) Nathan Litovitz 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3500 Forest Edge Drive, Silver Spring, MD 20906 ace of Disposition (Name of Date 20c. Location - City or Town, State Robert Goldman/Son 20b. Place of Disposition (Name of cemetery, cremetery or other place)
Judean Memorial 20e. Method of Disposition Jan. 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 18,1999 Olney, Maryland Garden 21. Signature of Funeral Shrvige-Licensee 22. Neme and Address of Fecility Ives Pearson Funeral Homes 2847 Wilson Blvd., Arlington, Virginia

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or real failure. List only one cause on each line. 22201 Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner physician and the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as e consequence of): 080 ō Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 94 signed by t 1 Yas 2 No 3 Probably 4 Unknown Hyperlipidemia ð 24b. Were autopsy tindings available prior to 24a. Wes an autopsy performed? Completed peed completion of cause of death? page 2 has certificale 1 Yes 2 No Be 25. Wes case referred to medical examiner? 26. Placa of Deeth (Check only one) 1 Yes 21 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? or Attending 1 Neturei Accident 5 Pending efter death. Director: Aft investigation 1 Yes 2 No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide To the Hospital of within 24 hours of To the Funeral Dicompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted. edical 29e. Certifier (Check only one) 290. Signature and this of qualifier 29c. License number 29d. Date signed (Month, Day, Year) 3526 30. Name and addres s of person who completed cause of death (Item 23a) (Type, Print) Drive Silver Spring 3801 John International Maryland backee 31. Dete filed Month, Day, Year) 32. Registrar's Signeture State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day **Physician** Margaret Olga Wolfe 4b. City, Town, or Location of Death 1/4c co... 1999 11:25am /Medical 4e Facility Neme (If not institution, give street end number) /4c. County of Deeth Examiner Kosedale Balt. Franklin Square 5. Social Security Number 6. Se center more Hospital If Under 24 Hrs. If Under 1 Yeer Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) Funeral Deys Hours Months 1□M 20 F 96 Director 218 03 8781 July 21,1902 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits achda ! 1 ☐ Yes 2 No Baltimore Maryland Essex Directo "naturel", or flams 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1315 Old Eastern Avenue 21221 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: White ğ 3⊠ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Housewife Own Home 8 altimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If tem 27 is marked of Veronica Young Oscar Baer 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 4532 Long Green Rd. Long Green , Md. 21092 Charles W. Faber (Grandson) 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Stete Parkwood Cemetery 1/18/1999 Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service-bicense 22. Neme end Address of Fecility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 OIM 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intervel Between Onset and Deeth **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical Examiner Examiner eu monia physician and s the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es a consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 1 Yas No 3 Probably 4 Unknown Division of Vital Records. à 24b. Were eutopsy findings available prior to 24a. Wes an autopsy performed? Completed Deen completion of cause of death? page 2 2 No 1 Yes 2 No al or Attending Physician: T s after death. it Director: After this certificat of in by the funeral director, p 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpetient 3 DOA 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? Naturel 5 Pending 1 Yes 2 No 2 Accident investigetion 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) within 2. 29b. Signeture and title of certify 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Drive Balt-more mD 21237

State Registrar

31. Date filed (Month, Day, Year)

JAN 1 9 1999

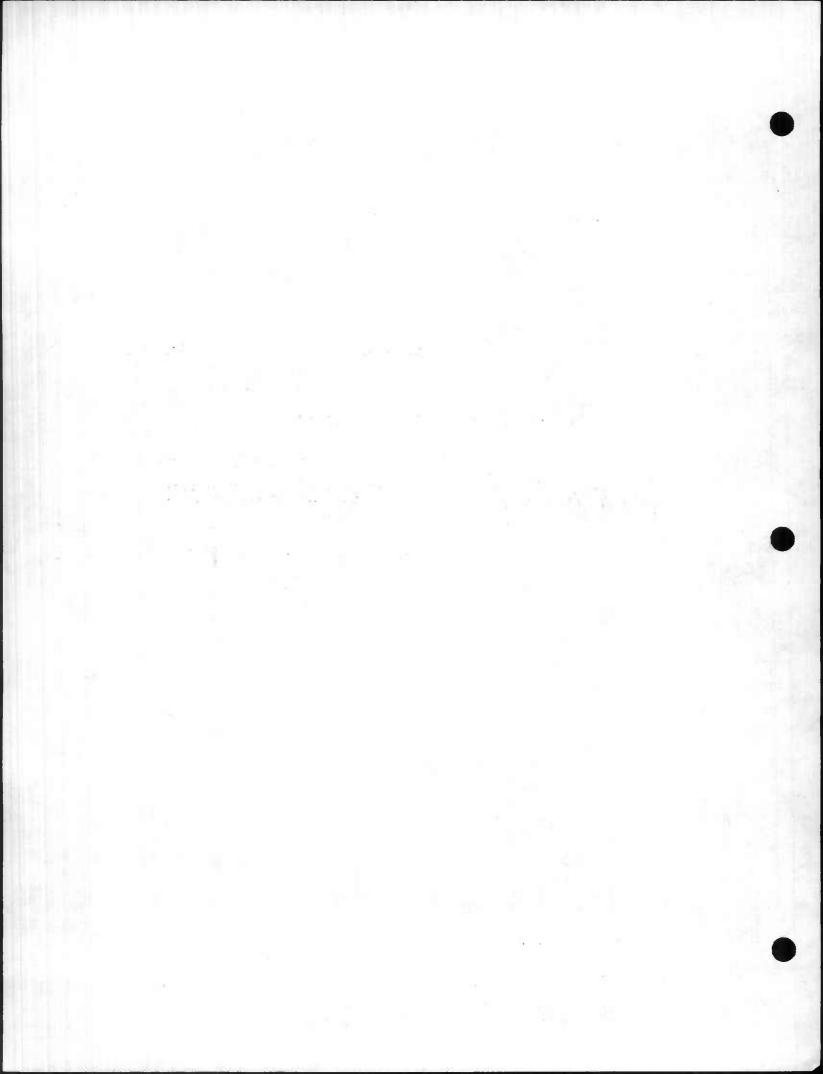
**DHMH 16 Ray 6/95** 

**ORIGINAL** 

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32. Registrer's Signeture

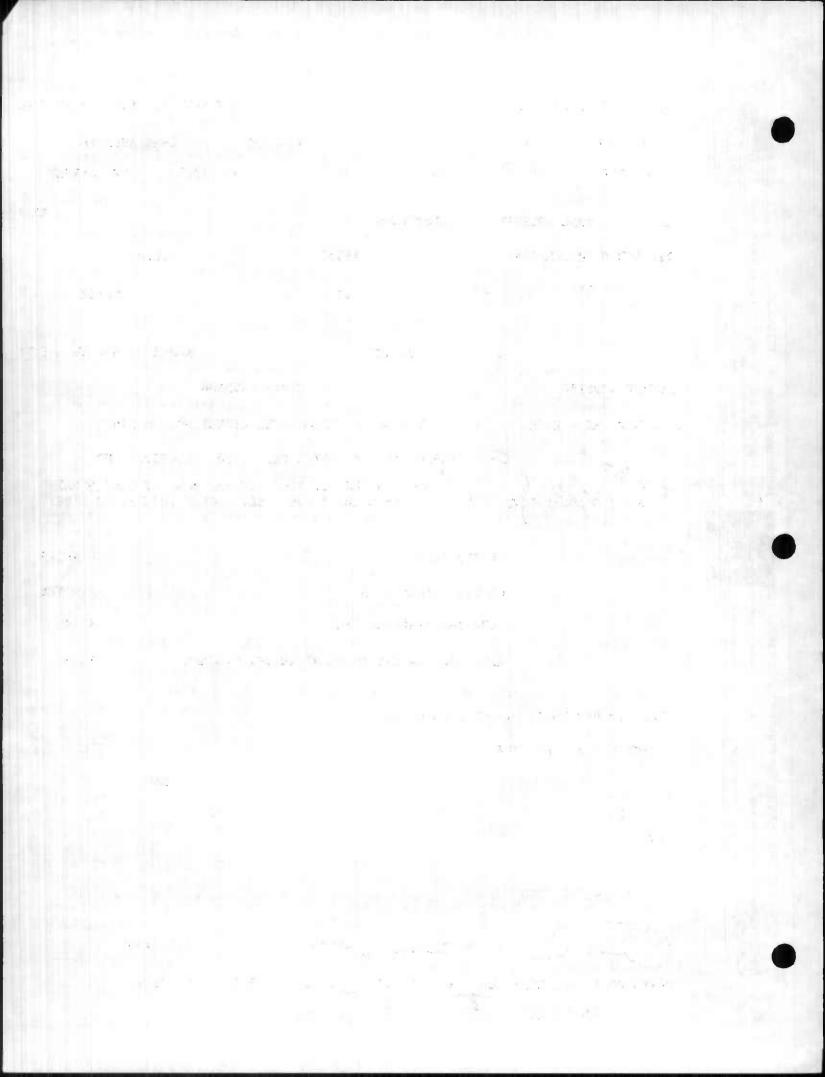


Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) JANUARY 11, 1999 **Physician** 3:19 P.M. EARL RICHARD WEBSTER /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** 714 CABIN BRANCH LANE LINTHICUM ANNE ARUNDEL if Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex **Funeral** Deys Hours Min 1 XX 2 F Yrs 80 5/2/1918 **NEW JERSEY** Director 153-07-1188 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. inside City Limits 10a, State 10b. County "natural", or itams 23a or 28a-f show 1 Yes 2 No Director ANNE ARUNDEL LINTHICUM 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a and injury or other traumatic avent, the Medical Experiment 2006. 714 CABIN BRANCH LANE 21090 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status Black, White, etc. 1 Never Married 20 Married Specify: WHITE Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MANAGER AMERICAN HEALTH & LIFE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) RICHARD WEBSTER ELSIE NEWMANN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEAN WEBSTER - WIFE 714 CABIN BRANCH LNE, LINTHICUM, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1XXBurial 2 Cremation 3 Removel In State 5 Other (Specify) MEADOWRIDGE MEMORIAL PK. 1/14 ELKRIDGE, MD 4 Donation Service Licenses 22. Name and Address of Facility
RAYMOND C. FINK FUNERAL HOME OF GLEN BURNIE KELLY GREGORY FINK 426 CRAIN HWY., S.W., GLEN BURNIE, MD 21061 23a. Perfl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only age cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical SUDDEN DEATH MINUTES Examiner Due to (or es a consequence of) Physician/Medical Examine CARDIAC DYSRYTHMIA MINUTES physician and s the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) YEARS Box 68760. CORONARY INSUFFICIENCY Due to (or es e consequence of) 65 for use as ATHERIOSCLEROTIC CORONARY ARTERY DISEASE YEARS 23b. Did tobacco use contribute to the cause of death? ed by the a Part ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. o 1 Yes 2 No 3 Probably 4XX nknown INSULIN DEPENDANT DIABETES MELLITUS signed b þ law requires 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en autopsy Completed peen CHRONIC RENAL FAILURE certificata has b The 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director, Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 10 1 Yes 2XXVo 1 | Inpatient 2 | ER/Outpatient 3 | DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Caturel 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hour.
the Funersi Direction \*\*Exertifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifier Medical within 24 ho To the Fune completely f the 29b. Signature and little of certifier 29d, Date sloned (Month, Dav. Year) 29c. License number D19991 1/12/1999 30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) DAVID ROSE, MD, SUITE 500, 200 HOSPITAL DRIVE, GLEN BURNIE, MD 21061 31. Date filed (Month, Day, Year) 32. Regis ar's Signature State JAN 1 9 1999

**DHMH 16 Rev 6/95** 

Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death January /6 / ... Taath 4c. County of Death Month **Physician** Anna R. Willis 12:30 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Cen Rosedale W Undar 24 Hrs. 8. Date of pital Baltimore Franklin Javare Hos 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 20 F Months Yrs. 215-24-1906 82 Director Feb 8, 1916 Kentucky Usual Residence of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. inside City Limits show 1 ☐ Yas 2X No MD Baltimore Baltimore Director 28a-t 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? "natural", or flams 23a or must be 8018 Eastdale Rd 21224 USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian, 11 Marital Status 12. Was Decedent Evar in U,S. Armed Forces? Biack, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Nevar Married 2 Married 1 ☐ Yes 2X No Specify: Specify: à 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Important: If Item 27 is marked only injury or other to Henderson Bentley Virgie Ethel Whitaker 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. informent's Neme/Reletionship (Type, Print) Marvin Willis Jr 335 Stonecastle Ave /son Reisterstown, MD 21136 20b. Place of Disposition (Name of cematery, cremetory or other place) 20a. Method of Disposition Jan 19 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1999 Oak Lawn Cemetery Baltimore, MD 22. Name and Address of Facility Connelly Funeral Home of Dundalk 21. Signature of Funeral Service Licenses 00 Inthon 7110 Sollers Point Rd 21222 23a. Part1. Enter the disaar I, or complications that ceused the death shock, or heart tailure. List only one ceuse on each line. Approximate interval Between Onset and Death Do not enter the mode of dying, such as cerdiac or respiratory arrest, **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Lung One day Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequenca of): 980 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 ☐ Yas 2 Ñ No 3 Probably 4 Unknown by been si 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Panding investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicida a Euneral Direct Sets of Funeral Direct Sets of filled in by 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Division of Vital Attending Physician: death. ò Hospital within 2

this

altimore, Maryland 21215-0020

Pages 1

the death certificate be executed

Box 68760

P.O.

Records.

Jillis, Anna

**DHMH 16 Ray 6/95** 

Registrar

31. Date filed (Month, Dey, Year)

32. Registrer's Signature JAN 1 9 1999

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

MD

Salkini

Druk

January

21237

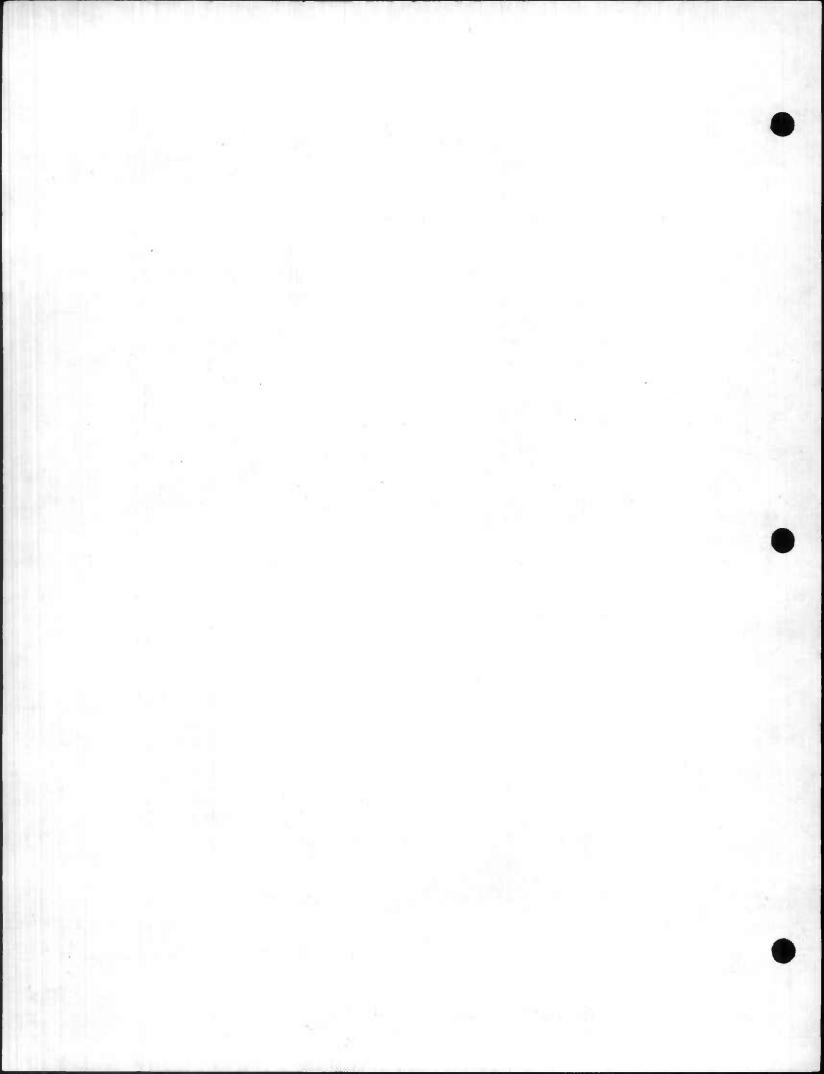
Maryland

**ORIGINAL** 

Franklin

mD

9000



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Month Veer Robert Drew yore 4a Facility Name (If not institution, give street and number) 99 5:00 am 4b. City, Town, or Location of Deeth 4c. County of Deeth Battmore If Under 24 Hrs. 8. Dete of Birth Hours Min. 8. Dete of Birth Affairs Balkimore 7. Age (In yrs. lest birthdey) Veterans If Under 1 Year 5. Social Sacurity Number 9. Birthplace (State or Foreign Deys 12M 2DF 63 375-34-3102 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Battimore TYes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Couptry? 3620 Kolana 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indien, Black, Whita, atc. 11. Marital Stetus 1 D as 2 No It Yes, Give Year or Dates: 1 Nevar Married 2 Married 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Mary 16s Elementary/Secondery (0-12) College (1-4or 5+) Police 18. Mother's Name (First, Middle, Meiden 17. Fathar's Nema (First, Middla, Last) Damrias Drewyore Stanle Henore 19e. Informent's Neme Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Doris Marylan Koland renvore IMONE 20b. Plece of Disposition (Name of cametery, cremetory or other p 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fugerel Service Licensee Tarre Many 21229 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in deeth) the respiratory 10 min 1 month Preumoria Due to (or as a consequence ot): Due to (or es e consequence of): 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown pulmonary 24b. Wera autopsy tindings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Corticobasilor dustonia 1 Yes 2 No 1 ☐ Yas 2 ☑ No 25. Wes case reterred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of

**Physician** /Medical Examiner

ò any Injury once.

**Physician** 

· /Medical

Examiner

10a. Stete

Directo

Funeral

P

**Funeral** 

Director

item 27 is marked other than "natural", or itema 23a or 28a-f ahow other traumatic avent, the Modical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or ite

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Examiner physician end the burial-tran Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Physician/Medicai 80 use

1 Naturel

2 Accident

3 ☐ Sulcide

29e. Certifier

4 Homicide

(Check only one)

PV

Completed

Be

To

Certification:

Medical

After t or Attending

efter death.

24 hours e Hospital

To the within 2

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28d. Describe how injury occurred

28c. Injury at Work? 2 No 1 TYes 28t. Location (Street and Number or Rural Route Number, City or Town, State)

South Greene St

28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) end manner as stated. 2 Medical Examinar: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signeture end title of certifie

5 Pending Investigation

6 Could not be determined

29c. Licanse number 1310541

29d. Data signed (Month, Dey, Year)

Bultimore, MD 21201

1/2/1999

30. Neme and address of person who completed cause of death (item 23e) (Type, Print)

AMAR

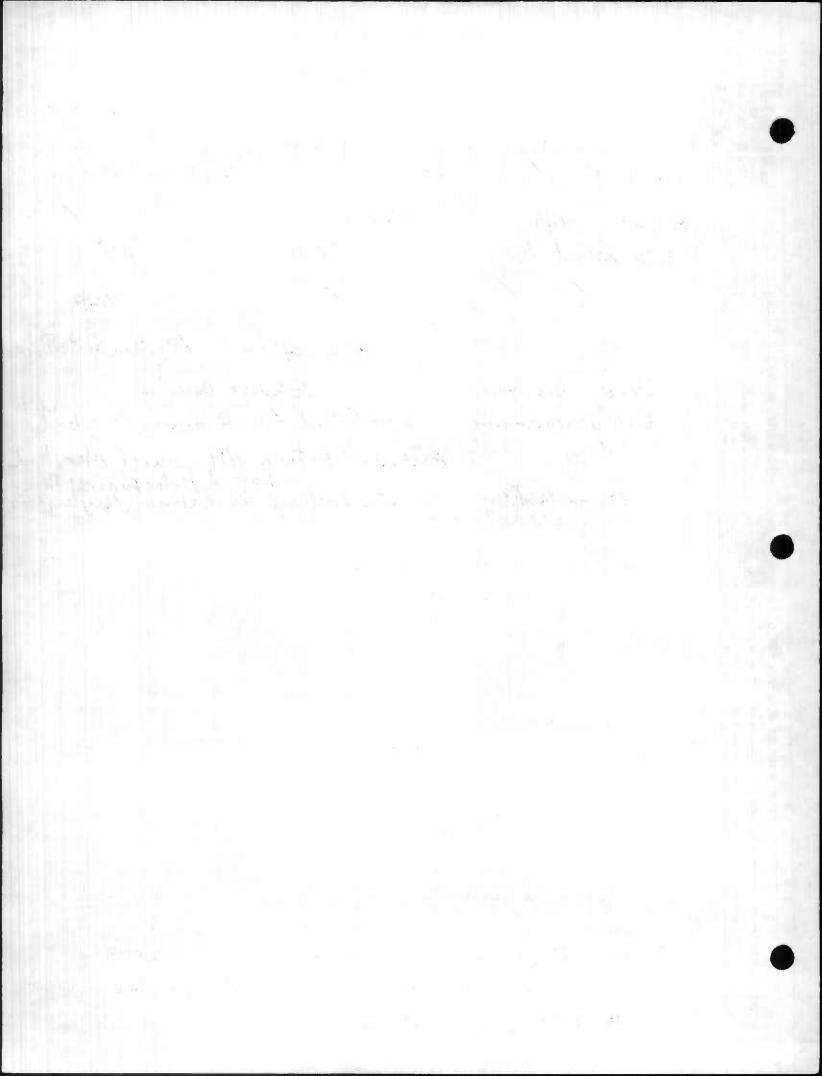
VA medical

32. Registrer's Signeture

Registrar

19

31. Data tiled (Month, Dey, Yeer)



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. 2. Date of Death

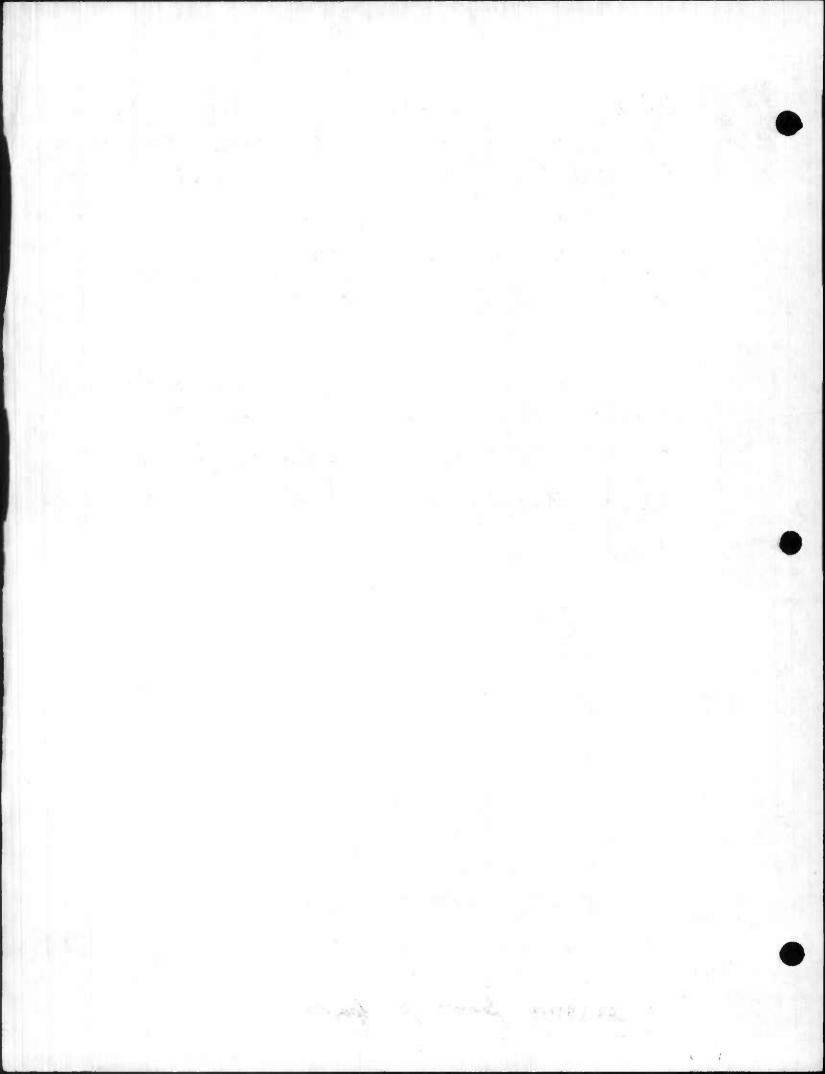
							icate of	Death	F	Reg. No.	00	000
	Physic /Medi		1. Degedent's Name (First, Middle, La		Zie	ntak			2. Date of Dea	Dey	79	O410
	Exami Funeral Director		4. Facility Name (If not institution, given to the facility of	sing li	nter e (In yrs. last		Under 1 Year onths Days		8. Date of Birth	Bal	+Ima	e City (State or Foreign LAND
	ter death with the Maryland flerrs 23s or 28s-f show		Usual Residence of Decedent  10a, State 10b, County		0 1				08/0	SIT		
											10d.	insida City Limits 1 ■ Yes 2 □ No
		Director	10e. Street and Number	A			Of. Zip Code	KE		10g. Citizen of	Whet Country's	
		al D	603 S. PATTE	RSON PAR	K AVE		21	224		U.S.	Α.	
020		by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yas 2 No If Yes, Give Year or Dates:	es? If Yes, specify Cuban, Mexican, Pue ISNo  1 ☐ Yes 2 ☑ No Specify:				Specify Yes or No- rto Rican, etc.)  14. Race - A Black, W Specify:			ndlan,
21215-0020	within 72 hours iena. r than "naturai", the Medical Exe	Completed	15. Decedent's Ec (Specify only highest gra Elementery/Secondary (0-12)	da completed)	Completed) (G life College (1-4or 5+)		IOT use retire	during most of work ed)	ing	16b. Kind of Business/Industry		ry
pu	ntai Hyg	To Be Cor	17. Fathar's Name (First, Middla, Last) THEODOR	.K	18. Mother's Name (First, Middle, Meiden Sum							
	alth and 27 is m		19a. informant's Neme/Relationship (					tend Number or Run				de)
ore	S to to		20a. Method of Disposition  1. Burlal 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Ramoval from State	cema	of Disposition atery, crametor STANI	y or other pla	CEME. 1		20c. Location - BALTIN		
Balt	Department of important: if any injury or once.		21. Signature of Funeral Sarvice Licensee  Charles for Funeral Sarvice Licensee  22. Name and Address of Facility KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 21222									
	hysician /Medical Examiner		23a. Part1. Enter the disaase, or comshock, or heart failura. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused one cause on each ling.						rest,	int	proximete erval Betwaan iset and Deeth
	ansit	Examiner		b. —		a consequence						V
68760,	g physician and ss the bunal-transit	edical Exa										
X OX	_ O 6	100		d								
<u>a</u> 3	y the	by Physician/N	Per II. Other significant conditions or Concer of Seville Dem	Producting to death but Tale	ut not resulting	g in the under	ying ceuse gi	ven in Part I.				y 4 Unknow
Records, P	8 8	Completed	Sevile Dem	erTia N	ish I	elusio	ns		24a. Was e perfor	en autopsy med?	aveilet	autopsy findings ble prior to etion of cause th?
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Of VICEI	s certificate has t director, page 2 s	o Be	25. Was cese referred to medicei examiner?  1 ☐ Yas 2 ☐ No	Hospitai:	-1 0DED#	Outration 6	Ott	26. Place of Deat				
io noi	or Attending Phy iffar death. Mector: Affer this in by the funeral of	atlon: To	27. Manper of Deeth  1 Matural 5 Pending  2 Accident Invastigation	1 ☐ Inpatial  28a. Date of Injur (Month, Dey	y 28b	Outpatient 3 b. Time of Injury	28c. inju Wo		g Home 5 Rasidence 6 Other (Specify)  28d. Describe how injury occurred			
		Certification:	3 Suicide 6 Could not be determined	building, etc	Injury - At home, farm, street, factory, office etc. (Specify)					281. Location (Street end Number or Rural Route Number, City or Town, Stele)		
To the Hoenitel or	within 24 hours a To the Funeral Completely filled	Medical	one) 2 Medical Exam	raician: To the best of iner: On the basis of and manner sta	examination a	ige, deeth occi and/or investig	ation, in my o	opinion, deeth occur	ed at the time, d	late and place,	and due to the	cause(s)
)			29b. Signature and title of certifier	med - S	queia	list				ANUAR		
	9		30. Name and address of person who of WENECLEA NAVA	FRAO, HD.	eeth (Item 23s	(Type, Print)	DADW	ty, BAL	TIMORE	MAR	ILAND	21231

State Registrar

JAN 1 9 1999

32. Registrar's Signature

B. Sparky



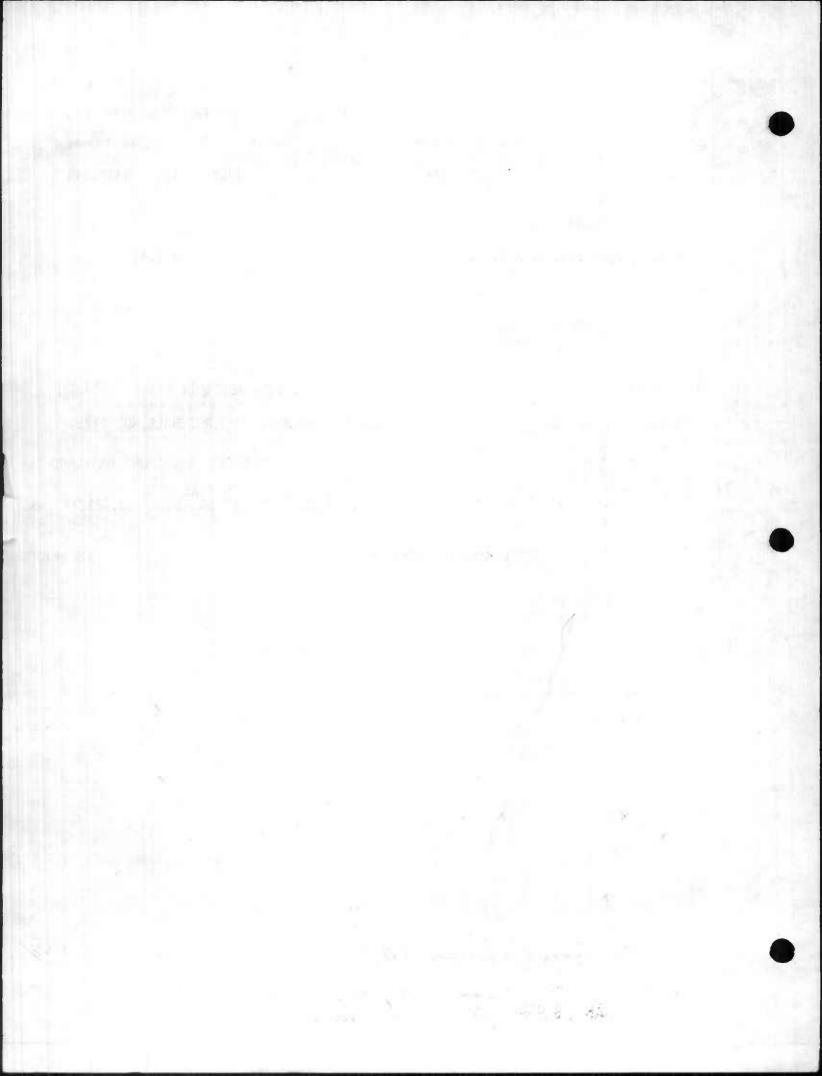
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** BARBARA M. ZEILER /Medical 4b. City, Town, or Location of Death 14 1999 4c. County of Death 11:42 AM 4a Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F Months 85 Director 215-09-4407 JULY 19,1913 MARYLAND Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 100 Director 28a-f MD. BALTIMORE GLEN ARM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 11630 GLEN ARM ROAD APT. 202 21057 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Married 'natural', or 1 Yes 2 No Specify: WHITE Specify: þ 3 ₩idowed 4 Divorced Completed 15. Decedeni's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC aktimore, Maryland 17. Fether's Name (First Middle Last) 18. Mother's Name (First, Middle, Meiden Sumame, Be Pages 1 and 2 should be nent of Health and Mental FRANK MICHEL BARBARA HERRMANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2 Item 27 FRANCIS ZEILER/SON 8114 OLD PHILADELPHIA ROAD, ROSEDALE, MD. 21237 Method of Disposition

1 A Burial 2 Cremelion 3 Removal from State 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 4 ☐ Donetion 5 ☐ Other (Specify) SACRED HEART OF JESUS 1/16/99 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. CONKLING STREET, BALTIMORE, MD. 21224 Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final PULMONARY EMBOLUS disease or condition resulting in death) 18 HOURS Examine Due to (or as a consequence of): Examiner sician and bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Myocardial Infarction à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Massive Gastrointestional Bleeding 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After or Attanding 5 Pending s after death. 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 9 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end litle of certifie Dealer D16492 30. Neme and address of person with completed cause of death (Item 23a) (Type, Print) P. DIZON, M. D.

Day, Year) 32. Regis ROAD, TOWSON, MARYLAND 21204 7620 YORK State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death **Physician** Month Edward Woodrow Beasley, Jr. 4b. City, Town, or Location of Death 3 /Medical 4e. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hagerstown
If Under 24 Hrs.
Hours Min.

Min.

Min.

Min. Washington County Hospital Washington If Under 1 Yaer 5. Social Security Number Birthplace (Stata or Foraign Country)

Mary land 6 Sax 7. Age (In yrs. last birthday) Funerai 10XM 2□ F Deys Yrs. 55 Director 218-40-4173 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show trsumstic event, the Medical Examener must be notified at 1 Tyes 2XXVo Director West Virginia Berkeley Falling Waters 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 6 238 144 Broadview Court Funeral 25419 USA 11 Marital Status 12. Was Decedant Evar in U,S. Armed Forces? Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puanto Rican, etc.) 14. Raca - Amarican Indian, Black, Whita, etc. filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Yas ZENo Specify: 6 by 1 Specify: White 3 Widowed 4 Divorced 'natural'. Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry el Hygiena. Elamentery/Secondary (0-12) College (1-4or 5+) Mechanic Door Manufacturer 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) . Pages 1 end 2 should be fill iment of Haalth and Mentel Hitant: If Item 27 is merked oth Edward Woodrow Beasley, Sr. Nellie Eileen Kershner 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) nt of Haalth a if Item 27 is or other tra Denise R. Johnson/Daughter 11330 Youngstoun Dr. Apt.1706 Hagerstown, MD 21742 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Greenlawn Memorial Park 1-7-99 Williamsport, Maryland 21. Signature of Funeral Service Licenses 22. Nama end Addrass of Facility Osborne Funeral Home disease or complications that caused the daeth. Do not anter the mode of dying, such as cardiac or raspiratory errast, alturn. Ist only ona causa on each line. Approximate Interval Batween Onset and Deeth **Physician** Due to (or es a bonsequance of): Coronary artery Lusiese /Medical Immedieta Causa (Final hours disease or condition resulting in death) Examiner Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cousa (Disaasa or Injury that initieted avants resulting in daath) Last attanding physician for use as the burie Physician/Medical Dua to (or as a consequance of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of cause of daath? Completed 24a. Was an autopsy performad? 1 Yes 2 No 1 Yes 2 No certificate Be 25. Was casa rafarred to medical 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatiant 2☐ ER/Outpatlent 3☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2₽No Certification: To this 27. Mannar of Death 28e. Deta of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 1 Watural 5 Panding 28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 1 Yas spital or Attenditions after deeth. 2 Accidant Invastigation 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homleida To the Hospital of within 24 hours a To the Funeral D completely filled in 11 Certifying Phyeician: To tha best of my knowledga, daath occurred at the time, date end plece, end dua to tha causa(s) and mannar as stated.

Medical Examinar: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date end plece, and due to tha cause(s) end mannar statad. Medical 29a, Certifiar 29b. Signature and titla of certifier 29c. Licansa number

State Registrar

31. Data filed (Month, Day, Year)
JAN 0 6

F PURIS. 32. Registrer's Signature

30. Neme and eddrass of person who complated cause et death (Itam 23e) (Type, Print)

366 HULL ST HAGERSTOWN

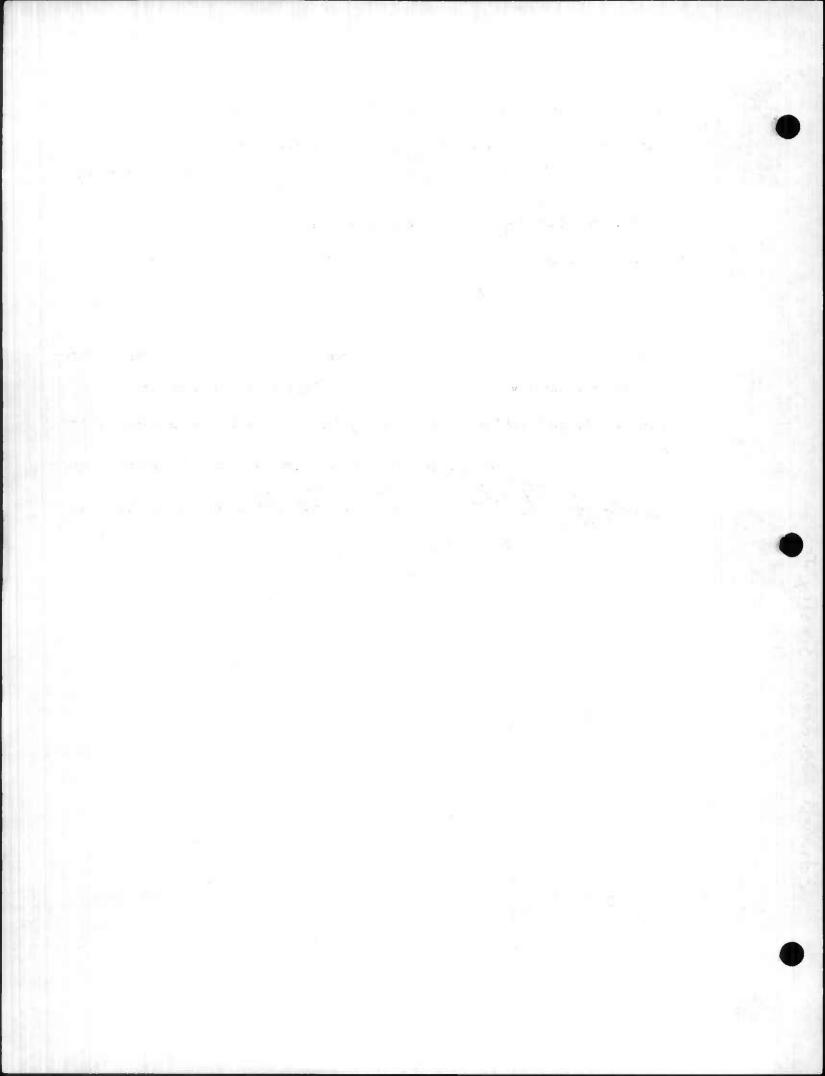
29d. Deta signed (Month, Day, Year)

Baltimore, Maryland

Woodrow

Fdward

Division of Vital Records,



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death ı<sup>Dey</sup> 1999 **Physician** Month Pamela Baker Jan. 01 7:15 AM /Medical 4a. Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Baltimore County Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 20 F Vrs Director 186-54-2932 33 Sept. 24,1965 Germany Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Yas 2 No Director Anne Arundel Severna Park 10f. Zip Code 10g. Citizen of Whet Country? ò 533 Baltimore-Annapolis Blvd. 21146 "natural", or items 23a USA Funeral 12. Was Decedent Ever In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within 7 and Mantal Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) Sales Representative Oil Recycling 17. Fether's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be John Baker Kathe Geisser 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If item 27 la any Injury or other trau once. John Baker 1021 Jacks Mountain Road Fairfield, Pa. 17320 20b. Place of Disposition (Neme of cemetery, crametory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1-5-99 Fairfield, Pa. 17320 4 ☐ Donation 5 ☐ Other (Specify) Fairfield Union Cemetery 22. Name and Address of Fecility
Davis Funeral Home 21. Signeture of Funeral Servica Licensaa 12525 muso Bardbury Avnue Smithsburg, Md. anus 23a. Pert1. Enter the disaase, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximete Interval Batween Onset and Death **Physician** /Medical Immediata Cause (Final ANOXIA disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner physician and the bunal-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): for use as Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown Records, þ 24b. Were autopsy findings available prior to completion of causa of death? 24a. Wes en eutopsy Completed peed paga certificate 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, streat, factory, office building, etc. (Specify) 2 4 Homicide within 24 hours a
To the Funeral C
completely filled 1 Noteritying Physicien: To the best of my knowledge, death occurred at the time, date and pieca, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and time of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) AM-D43725 99 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

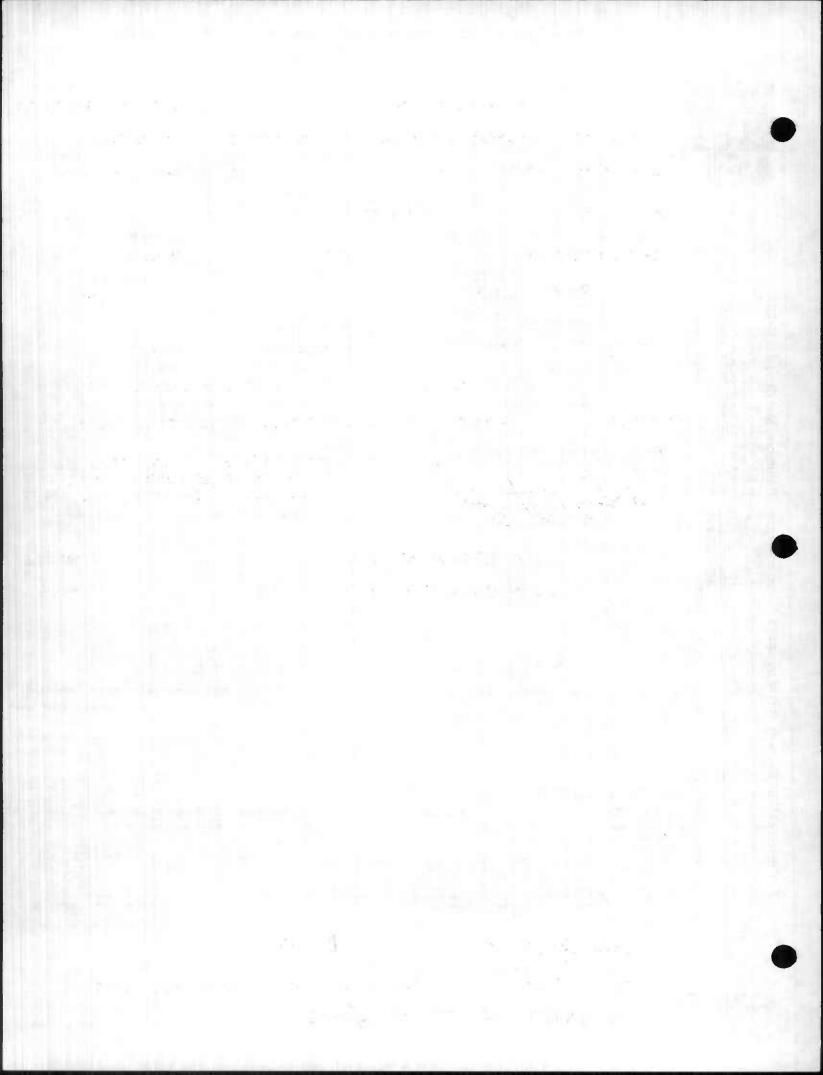
State Registrar 31. Date filed (Month, Day Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 0 0000

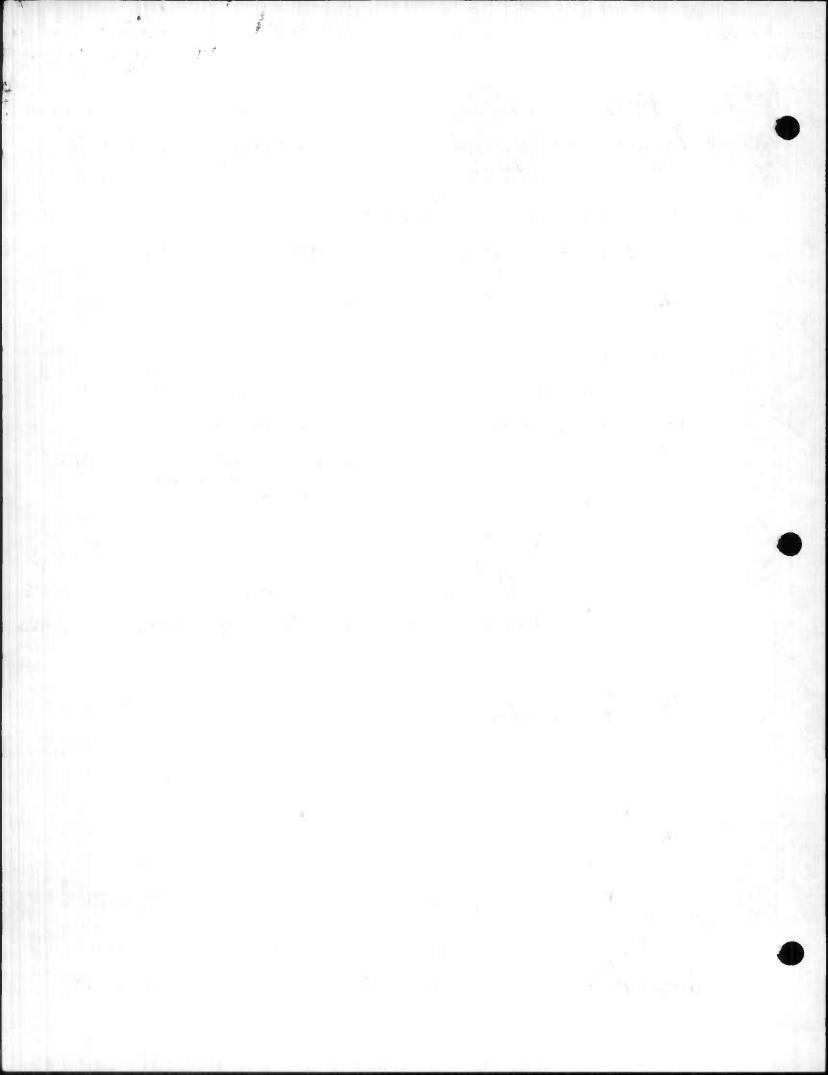
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	pu *	Usual Residance of Decedent  10a. Stete 10b. County	10	c. City, Town	or Location					10d. Inside City Limits					
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21215-0020	or or or or	3 ☐ Widowad 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Yaar or Detes:	r in U,S.	13. Was Decedent of It Yes, specify Cub  1 ☐ Yes 2 No		n? (Specify Yas Puarto Rican, et		ace - Ameri ack, White						
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Baltimore,	2 = 2	1X Buriel 2 ☐ Cremation 3	Removal from Stata		crametory or other ple		116100								
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Ва	permit. Peg Department Important: i any injury o	> R Lang /	atters	/	254 E. M	IAIN S	T., WE	STMINSTE		MD. 21157					
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4	Physician								i	Onset and Deeth					
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. METASTA	TIC M	ELANOMA					6 MONTHS					
		Due to (or es a consequence ot):													
	nsit	a ACUTE RENTAL FAILURE													
_	cate be executed physician and s the burial-trensit	Sequentially list conditions, if eny, leeding to immediate	Due	to (or es a co	nsequence of):				1						
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0	0 0 0	Part II. Other eignificant conditions	contributing to death but n	ot resulting in	he underlying ceuse gi	van in Pert I.	23t	Did tobacco use c	ontributa	to the cause of death?					
0	res that the de signed by the eff be deteched if by Physic							1 ☐ Yee 2X No	3 □ Pro	obably 4 Unknown					
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ior	Attending In death.  ector: After by the fune iffication	Neturel 5 Pending 2 Accident Investigati	on	,		Yes 2□N	0								
Division	tal or Attanding P rs effer death. al Director: After led in by the funer: Certification:	3 Suicida 6 Could not determine	28e. Place of injury building, etc. (5		n, street, factory, office			ation (Street end Nur or Town, Stete)	nber or Ru	ural Route Number,					
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	To the comple	29b. Signeture and title of capillary	SU HD		29c. Licen	se number 38915		29d. Date sign		h, Day, Year)					
		30. Name end eddress of person w	completed cause of deeth	(item 23e) (T	ype, Print)										
		KHALIL A. FR	EIOI 2	95 STC	NER AVE.	WES	TMINST	ER, MD.	2115	7					
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DHMH 16 Rev 6/95



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		State of Maryla	Certificate		Reg.	99 1	10863
Physic /Medi		1. Decedant's Name (First, Middle (ast)			2. Data of Death	Day Year	3. Time of Death 9:10 P. M.
Exami			i. last birthday) If Undar 1	4b. Siby, Town, or Lo	cation of Death  URL  8. Date of Birth (Month, Day, Ye)		h  (1 C D)  hplaca (Stata or Foraign untry)
Director		214-07-7969 1 M 7 85	Yrs.	Days Hours Min.	May 25 1		ryland
the Maryland 28s-f show notified at	tor	10a. Stata 10b. County 10c. C	ity, Town or Location Burtonsville				10d. Insida City Limits
th with the M	Funeral Director	10e. Street and Number 3915 Blackburn Lane	10f. Zip Co	20866	7	Citizan of What Co.	untry?
The day	b	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedant Ever in UArmed Forcas  1 Never Married  17 Yas, Giva  Yaar or Datas:	U,S. 13. Was Decedan If Yas, specify	nt of Hispanic Origin? (Specular) Cuban, Maxican, Puarto Spacify:	ecify Yes or No- Rican, atc.)	14. Race - Amar Bleck, White Specify:	
21215-002g awithin 72 hours at plens. r than "natural", or the Medical Exam	Completed	15. Decedent's Education (Specify only highast grada completed)  Elamentary/Secondary (0-12) Collaga (1-4or 5+)  UNKNOWN	16a. Decedant's Usual C (Giva kind of work of lifa. DO NOT usa			etail, po	ost exchange
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Maryland 42 should be the h and Mental Hyp 7 is marked other traumetic event.	70	Lafayette Langral  19a. Informant's Neme/Ralationship (Type, Print)		Ma Street and Number or Rura	-	reighton	Fin Code)
- 일등하는		Mrs. Ann Bradway — sister		n Ave., Sali			ip Code)
Baltimore, eemit. Pages 1 a bepartment of Her moortant: If Nem ny injury or othe fibe.		20a. Method of Disposition 20b.  20b. 20b. 20b. 20b. 20b. 20b. 20b. 20b.	Place of Disposition (Nema cematary, cramatory or other lington Natio	of er place)	Data 20c	Location - City or T	
Baltim permit. Pa Department Important any injury once.		21. Signatura of Funaral Sarvica Licensee	22. Nama and A		omas Fune	ral Home	
Physician physicien and ing physicien and ses the buriel-trensit	Medical Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disaase or Injury that initiated events resulting in death) Last	OVAS CUAS (or as a consequence of): OVAS CUAS (or as a consequence of): OVAS CUAS (or as a consequence of):	Accide. e pulmon	nt ary di	jegse	Intarval Batween Onset and Death  3 CLAYS  YEARS
, P.O. Box that the death cented by the ettendin deteched for use	y Physician/N	Part II. Other significant conditions contributing to death but not ran Dementia - Alzheimer	sulting In the underlying cause	sa givan in Part I.	23b. Did tobac	V	to the cause of death?
I Records, P.O. The lew requires that the site has been signed by the page 2 should be deteched.	Completed by				24a. Was an as performed	9	Were autopsy findings available prior to complation of causa of daath?
of Vital Re-	Be	25. Was casa referred to medical axaminar?  1  Yas 2 No Hospitel: 1 Inpatient 2	752/0 4-25-4 47 204	Other .	(Check only one)		
E series	ation: To	27. Mannar of Deeth 1 Natural 5 Panding 2 Accidant Investigation 28a. Data of Injury (Month, Day Year)	☐ ER/Outpatient 3☐ DOA  28b. Time of Injury  M	4 W Nursing Ho	ma 5 ☐ Residence 28d. Dascribe how li		nry)
Division ital or Attendi urs efter death ral Director: A	Certification:		noma, farm, straat, factory, o		28f. Location (Street City or Town, St	lafe)	
To the Hospital within 24 hours or the Funeral completely filled	edicai	29a. Certifier (Check only one)  1	owledge, daath occurred et t ation and/or invastigation, In	tha tima, deta and place, a my opinion, daeth occurr	and dua to tha cause ed et the time, date	i(s) and mannar as and placa, and due	steted. to the ceuse(s)
To the comp	Me	29b. Signature and title of certifier	29c. L	icense number	29d.	Date signed (Month	n, Day, Year)
		80 Name and edgraped paren who completed source of de	MD CMS 1	55700	5	116/0	79
		Name and eddress of person who completed cause of dame of the line	1 Box 2018, _	SAlisbury,	MD 21	802- 2	2018
Sta Registr	_	31. Data filed (Month, Day, Yaar)  JAN 0 7 1999  32. Registrar's Sign	atura 4				

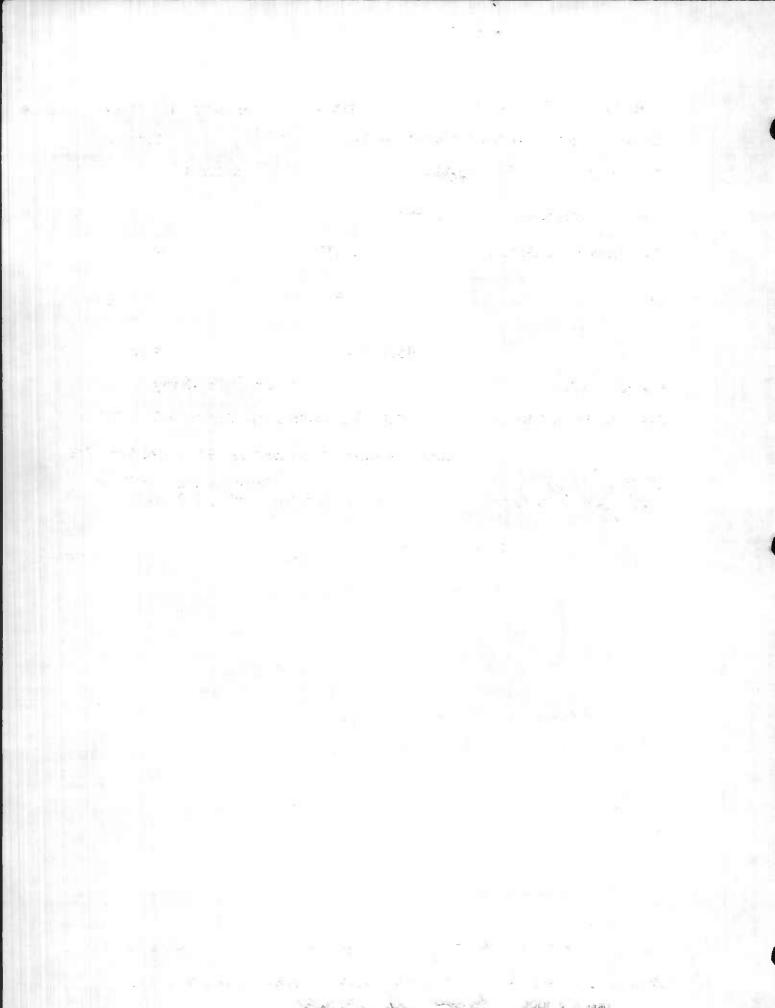


State of Maryland / Department of Health and Mental Hygiene 9 0 86 ls

					Certifi	icate of	Death	F	Reg. No.	0	000
	Observatori	1. Decedent's Name (First, Middle, La			7/10			2. Date of Dea Month	nth Dey	Year	3. Time of Death
	Physician /Medical	HARRIET E	LIZABETH			DOWN	ING	JANUARY	05	1999	1:40 PM
١	Examiner	4a Facility Name (If not institution, give					4b. City, Town, or L	ocation of Death	4c. Coun	ty of Death	
		Berlin Nursing	and Reha	abilitatio			Berlin	1	Wor	ceste	r
	uneral rector	212-12-3472	Sex 7. Ag	ge (In yrs. last bii 84		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 9 / 23 / 1	h (, Year) 1	9. Birthp Coun	lace (State or Foreign try) MD
pug	*_	Usual Residence of Decedent  10e. State 10b. County		10c. City, Tow	vn or Locatio	on			10d. Inside City		
не Магуія	be recorded an Director	MD Worce	ster	Berl	lin						Yes 2□No
ath with th	23a or 2 unit be n rai Dire	10e. Street and Number 113 Flower St.	Apt. 7		1	0f. Zip Code 2181			US	4	
020 nurs aftar dea	7 is marked other than "natural; or items 23s or 28s-f show traumstic avant, the Medical Exeminer must be notified at To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3XXVidowed 4 Divorced	12. Wes Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		If Ye	Decedent of I s, specify Cub Yes 2 X No	Hispanic Origin? (Spean, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)		aca - Americ ack, White,	
21215-0020 d within 72 hours af giena.	ner than "nature it, in wederal Completed	15. Decedent's E (Specify only highest gra Elementery/Secondery (0-12)	ducation ade completed) College (1-4or	5+)	(Give king	VOT use retire	dunna most of work	king	16b. Kind of		dustry
iled v	S S	17. Fether's Name (First, Middle, Last	4	1	Tomen	iaker	18. Mother's Nam	a (First Middle			
Maryland 12 should be file h end Mental Hyg	arked oth artic avar To Be	Franklin Webb	,					Belle C			
Mary d 2 sho	7 is me traume	19a. Informant's Name/Relationship ( Betty L. Lewis					and Number or Rulartins RI			n, State, Zip 21811	
Pages 1 end	= 0	20a. Method of Disposition  1  Buriel 2 Cremetion 3  4  Donetion 5 Other (Special	Removal from State	20b. Pleca o cemete	of Dispositio	n (Name of ary or other pla		Date	20c. Location		
Baltimo permit. Page Department	mportan any injur once.	21. Signature of Funeral Service Lice	* *		22. Na	ame and Addre	ess of Facility Bu	rbage F			
- 45		ILXIN/01	entage				am St. B		~	1	
	sician edical	23a. Pa Finter of disease, or complete shock, or have a fallured List only  Immediate Cause (Finel	one sadselon each I	ine.				or respiretory er	rest,		Approximate Interval Between Onset end Death
()	miner	disease or condition resulting in death)	a	Due to (or as a	411	01/	175				2 125,64
	je l		0	bue to (or as a	consequen	VI a	Luca.				
cuted	in end ial-transit Examiner	Sequentially list conditions,	b	Due to (or as a	consequen	ce of):					
J .	urial-t	Sequentially list conductors,  if any, leading to immediate cause. Enter Underlying Cause (Disease or injury C.									
68760 tificate be a	g physician end es the burial-transit ledical Examir	that initiated events resulting in death) Last	С.	Due to (or as a	consequen	ca of):				1	
Th cent	attending pl d for use est clan/Med		d							1	
P.O. B	signed by the attend be detached for us be detached for us by Physician/	Part II. Other eignificant conditions of									the cause of death?
HECORDS, P.O. BOX 58/50, elaw requires that the death certificate be axecuted	been signe should be d	PARMONE	, L I	Pace	un	le - V			an autopsy rmed?	av co	ere eutopsy findings eileble prior to mpletion of cause
T e	5 C/							101	res 2 No		death?
	certificata irector, pag	25. Was case referred to medical					26. Place of Dea	th (Check only o	ne)	_}	
> Selection	ni direc	exeminer?	Hospital:	ent 2 ER/O	utpatient	3 DOA Ot	her: 4X Nursing H	ome 5 Resid	denca 6 🗆 O	ther (Specil	y)
ION O	ector: After this certificate he by the funeral director, page iffication: To Be Com	27. Magner of Death  1 Neturel 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		Time of Injury	28c. Inju Wo M 1	rry at ork? ] Yes 2 ☐ No	28d. Describe h	now Injury occ	urred	
DIVISION OF it or Attending Phys after death.	al Director: After the din by the funeral Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Piece of in	jury - At home, fa tc. (Specify)	arm, street,	factory, office		28f. Location (5 City or Tox	Street and Nur vn, State)	nber or Run	al Route Number,
DIVISION Of VITA To the Hospital or Attanding Physician: within 24 hours after death.	To the Funeral Dir completely filled in Medical Cert		nyalcian: To the best minar: On the basis of end manner si	of examinetion er							
ro the	To the	29b. Signature and title of certifler				29c. Licen	se number		29d. Date sign	ned (Month,	Day, Year)
		1 Jun	m			D020	26	1	JAN	6-9	4.
1	il	30. Name and address of person who FEDERICO G. ARTH			(Type, Prin		OCEAN	PINES, 1	MD 2181	1	
		31. Date filed (Month, Dev. Yeer)		rar's Signature	4		John	~ ~~~~~ 1			

Registrar

JAN 0 6 1999 32. He Strar

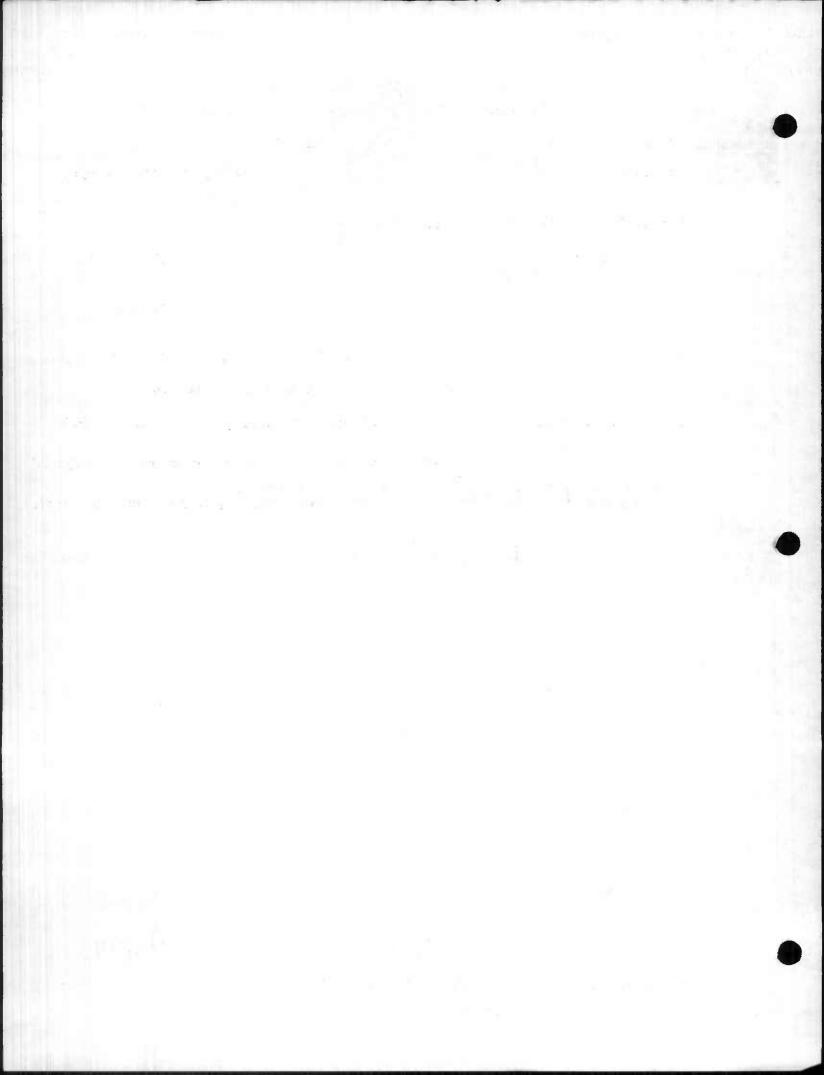


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Bea No. 99

ician				001		of Death		Reg. I	10. " -	00	0.0
ician	1. Decedent's Neme (First, Middle,	Last)					2. Dete o	f Deeth			Time of Death
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dical	4e. Fecility Neme (If not institution,	The second secon		uitalii		4h City Town	Janua , or Location of D		c. County		:25 AM
niner			,								
	11001 Holly Ro				Killada, 4 V.	Ridge1				oline	
al	5. Social Security Number	3. Sex 7. 1 ☐ M 2√2 F	Age (In yrs.	last birthdey)	If Under 1 Ye Months Da		Min. 8. Dete o	Birth Day, Yes	(r)	Birthpiece     Country)	(Stete or Foreig
or	217–30–8497		64	Yrs.			Febru	ary 10	, 1934	Mary	
	Usuel Residence of Decedent		40.00	* .	41						
	10e. Stete 10b. County		10c. Cit	y, Town or Loc	ation						Inside City Limits
읝	Maryland Carol	ine	R	idgely							I Yes 2 No
Director	10e. Street and Number				10f. Zip Cod	le		10g. 0	Oltizen of V	Whet Country?	
0	11001 Holly Roa	a			21	660		7.7		01-1-	
e a	11. Maritel Stetus	12. Was Decede	nt Ever in II	C 12 W		660	2 (Specify Vers		-	State	
ompleted by Funeral Director		Armed Force	es?		Yes, specify C	of Hispenic Origin Cuben, Mexicen, F	uerto Rican, etc.	)		k, White, etc.	ideit,
by F	1 Never Married 2 Marrie	If Yes, Give		1	☐ Yes 2页	No Specify:			Specify	<i>r</i> :	
Q P	3 Widowed 4 Divorced	Yeer or Dete	)\$: 						-	asian	
Completed	15. Decedent's (Specify only highest	Education grede completed)		16e. Decede	ent's Usual Oc	cupetion one during most of	f working	16b.	Kind of Bu	usiness/Industr	У
10	Elementary/Secondery (0-12)	College (1-4	or 5+)	life. D	O NOT use re	tired)	Working				
0	9		,	Pro	ductio	n worker		F	ood P	rocess	ina
Be C	17. Fether's Neme (First, Middle, Li	est)					Neme (First, Mic				2113
B	William	Nathaniel	Faully	nor Sr		Bessi	e Lee	Mont	ora		
2			raulki					Woot			
	19e. Informent's Neme/Ralationshi					reet and Number (					ie)
	George N. Fount	ain	Husbai			11y Road	, Ridge	Ly, M	aryla	ind 21	660
	20e. Method of Disposition			lece of Dispos emetery, crem			Dete	20c.	Location -	City or Town,	Stete
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	21. Signetate of Funerei Service Li		CO			Y Idress of Fecility	1/05	nea	r bei	ICOII, M	aryland
						neral Ho	me, P.A.				
1	pharts 1	. Reo	00			Second			on . Ma	rvland	21629
	23e. Pert1. Enter the diseese, or co shock, or heart teilure. List or	omplications that cau	sed the daet	h. Do not enta	r tha moda of	dying, such es ce	rdiec or respireto	ry errest,		Apr	oroximata
n	Groom, or rioure longro. Else of	ny ona couse on ooc	ii iii lo.								ervei Between set end Deeth
al	immediata Cause (Finei	ì	01-							2	
r	diseese or condition resulting in deeth)	· Lyr	npn	oma						2	mos
5		\	Due to (o	r es e consequ	ance of):						
Examiner		b. ———									
Kan	Companie by that conditions		Due to (o	r es e consequ	ience of):						
liii l	d env joeding to immediate										
	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying									i	
	Cause (Disease or injury that initiated events	c	Due to (o	r es e consequ	ence of):						
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/Medicai	Cause (Disease or injury that initiated events	ds contributing to deat			,	given in Pert i.	23b.	Did tobac	co uae cor	ntribute to the	cause of death
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by Physician/Medical	cause. Enter underlying Cause (Disease or injury that initiated events rasulting in deeth) Lest	cds contributing to deat			,	given in Pert i.	24e. \	1 □ Yee Vas an eu	200No	3 Probably	y 4 Unkno
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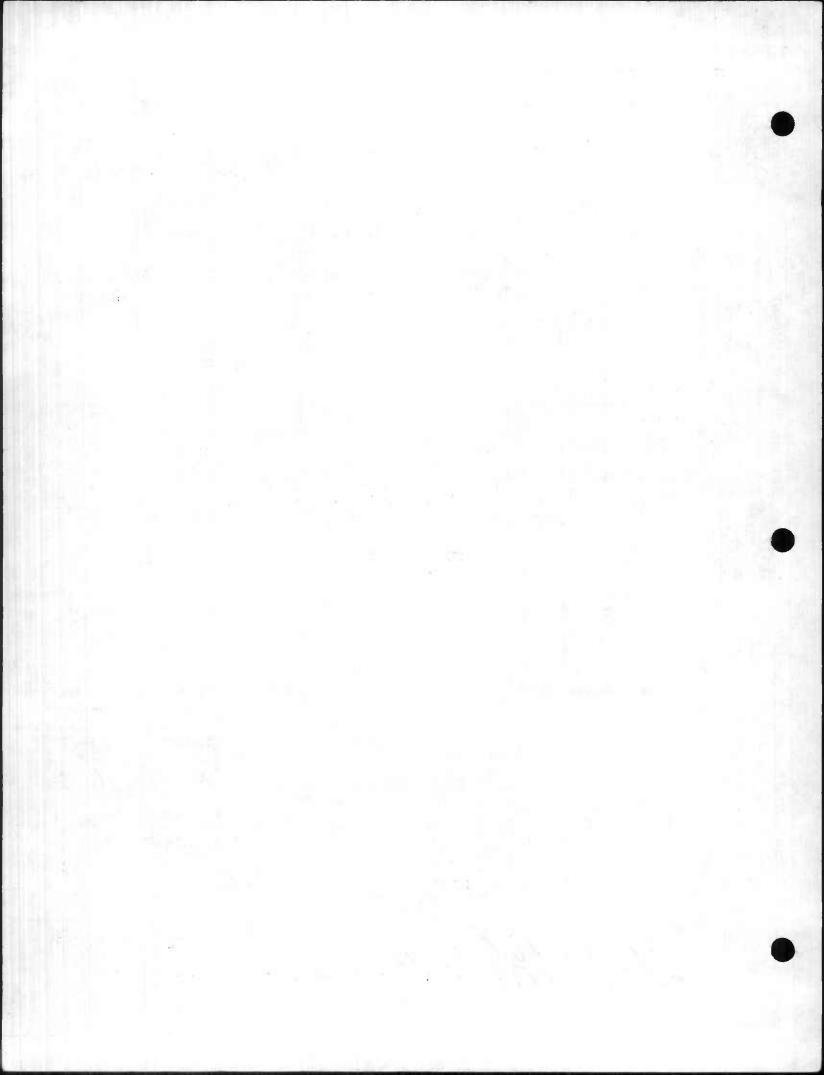
State of Maryland / Department of Health and Mental Hygiene

Physician /Medica Examine Funeral Director	al	Decedent's Neme (First, Middla, Le     Katie Ma     4a. Facility Nama (If not institution, gh	arie GLAS	SFORD			2. Data of Dec Month January	Day	3. Time of Dea 9 9:20 p.					
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						4b. City, Town, or								
					Will-de d	William		_ 1	nington					
		226-32-3202	Sax 7. Ag	e (In yrs. lest birt 69	Months	Days Houre Min		h y, Year) , 1929	9. Birthplaca (Stete or For Country) Virginia					
2 2		Usual Residence of Dacedent  10a, Steta 10b, County		10c. City, Town	or Location				and traile on the					
a-f show	ctor	Maryland Washing	gton		msport				10d. Inside City Lir 1 ☐ Yes 21☐					
23a or 28	Funeral Director	10e. Street and Number 10917 Donelson Dr	rive		10f. Zip (	21795		10g. Citizan of W						
	ò	11. Merital Stetus  1 □ Navar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forcas? 1  Yas 2  If Yes, Give Yeer or Detes:		13. Wes Decede If Yes, specif	ont of Hispanic Origin? (Sty Cuban, Mexican, Puer	Specify Yas or No- to Rican, etc.)		14. Race - American Indian, Bleck, White, etc. Specify: White					
or should be lised within 72 ho hend Mental Hygiena. I's marked other than "natur Teumatic event, the Medical	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondery (0-12) 0-12	ducation ade completed) College (1-4or 5	0+1		Occupation done during most of wo retired)	orking	18b. Kind of Bus						
r. Brate	ပ္ပ		0	h	omemaker				own home					
Hobe	Be	17. Father's Nama (First, Middle, Last		1		18. Mother's Ne	me (First, Middle,		•					
Men	2		Bryant Hall				Lucy Lee Holley							
f Heelth and Mer f Heelth and Mer from 27 is marks other traumatic		19e. Informent's Neme/Reletionship		1										
theelth m 27	-		stora/nusba											
permit. rages I and Department of Heelth Important: If Item 27 any injury or other tr once.		Mr. John E. Glassford/husband 10917 Donelson Drive, Williamsport,  20e. Method of Disposition  1\(\text{Burlel 2}\) Cremetlon 3 \(\text{Ramovel from Stete}\) 4 \(\text{Donation 5}\) Other (Specify)  20b. Plece of Disposition (Neme of cemetery, cremetory or other plece)  Cedar Lawn Memorial Park 1999  Hagerst												
Departr Importu any inju		21. Signatura of Funeral Service Lice	nsee Maria				linnich E	uneral I						
hysician /Medical Examiner		23a. Pert1. Entar the disease, or com- shock, or heert fellure. List only Immediate Cause (Finel disease or condition resulting in deeth)	e. A	Due to (or as a c	te car	resa wit			Approximate Interval Between Onset and Death					
ng physicia as the bur	8	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b											
d for use	Physician/	Part II. Other significant conditions of	d	ut not resulting in	the underlying on	use given in Part I	23h Dida	ohecco use con	tribute to the cause of de					
igned by the a			on the street of	ar not resouring in	una andonymy oa	uso givan in rott i.			3 Probably 4 Unk					
ite has been signed by the attendit	Completed by						24a. Was perfo	en eutopsy med?	24b. Were autopsy findin available prior to complation of cause of death?					
	Ö						101	res 200 No	1 Yas 2 No					
this certificate	Re	25. Wes case raferred to medical exeminer?					eth (Check only o	ne)						
울등	0	1 ☐ Yes 🖫 ☐ No	Hospitel: 1   Inpatie				Homa 5 Rasio							
the second	Ö	27. Mennar of Death  ↑ Naturel 5 □ Pending	28a. Deta of tnju (Month, Da)	ry Year) 28b. T		c. Injury at Work?	28d. Describe I	now injury occurre	bed					
efter deeth. Director: Aftel	Certification:	2 Accident Investigetio 3 Sulcide 6 Could not b 4 Homicide determined	On Dines of Init	ury - At home, fer c. (Specify)	m, street, fectory,	1 ☐ Yes 2 ☐ No offica	28f. Location (S City or Tow		or or Rural Route Number,					
t hours e cuneral D ely filled		29e. Certifier 152 Certifying Pt (Check only 2/1 Medicat Example)	nystotan: To the best of	of my knowledge	, deeth occurred at	t the time, dete end plac	a, end due to the	ceuse(s) and man	nner as steted.					
29e. Certifier (Check only one)  29e. Certifier (Check only one)  20 Medical Examiner: On the basis of examination and mannar steted.			and mannar ste	eted.										
and m			0 60			License number	1		(Month, Dey, Year)					
within 2 To the comple	- 1		1 / //m V		D112-61 Jan 4 99									
within 24 hours effectors to the European of the Completely filled in by the fundamental Completely filled in by the fundamental Completely filled in by the fundamental Completely filled in the fundamental Completely Com		- / X/// 1	VIII OF			111166	30. Name and additions of Derson who completed cause of deeth (Item 23a) (Type, Print)  H.N. WRIKS MD 580 NevThern AV Hypersliving, WI,  31. Data filed (Month, Dey, Year) 1999 32. Registrar's Signature							
within 2 To the Complete		30. Neme end address properson who	completed cause of de	eeth (Item 23a) (	Type, Print)	111111111111111111111111111111111111111	.1	1	0					



MIKAYLA JANE GIBSON State of Maryland / Department of Health and Mental Hygiene 0 0007

Physician	1. Decedent's N	eme (First, Middle,		u/09 3=	18-99-01				Mo	te of Deeth	Dev	Year	3. Time of Dea
/Medical	MIKAY	LA JANE	E GIBSON						JA	N. :	3, Dey 1999	1	0716 A
Examiner			give street and number L CENTER	ber)			4	b. City, Town, LaPLA		of Deeth	4c. County CHARL		
Funeral Director	5. Social Securit  N/A  Usual Residence		6. Sex 1 □ M 2 1 F	. Age (In yrs	: last birthday) Yrs.	If Unde Months	Deys		lin. (Mc	te of Birth onth, Dey, aber]	Year) 9,199		leca (Stete or Fo try) [arylar
ž =1	10a. Stata	10b. County		10c. C	ity, Town or Lo	cation	-					10	Od. Inside City Li
feed for	MD	Charl	.es	L	a Plat	a							1 ☐ Yes 2]
be notified Director	10e. Street and I	Number				10f. Zij	Code			10	g. Citizan of V	Vhat Coun	try?
al D	6727 G	len Alb	in Rd.				206	46			USA		
Examiner must be notified at Examiner must be notified at 1 by Furneral Director		s erried 2 Merrie d 4 Divorced	12. Wes Deced Armed Ford 1 Yes 2 If Yes, Give Year or Det	as? L <b>X</b> No				ispanic Origin? in, Mexican, Pu Specify:	(Specify Ye Jerto Rican,	etc.)	Blec	e - Americ k, White, d Whi	etc.
t, the Medical		15. Decedent's pecify only highest econdary (0-12)	s Education grade completed) College (1-4	for 5+)	16a. Deced (Give I life. L	lent's Usu kind of wo DO NOT u	ork done	furing most of	working	1	6b. Kind of Bu	isiness/Ind	lustry
avent, 1	17. Father's Nen	ne (First, Middle, L	ast)					18. Mother's I	Nama (First,	Middla, M	laidan Sumem	Θ)	
Se ev	Nichol	as Alle	n Gibson	n				Monic	a Mar	ie I	Frantz		
	The second second	Neme/Ralationsh			19b. Mailin	g Addras	s (Street	and Number of	Rural Route	Number,	City or Town,	Stete, Zip	Code)
22	Monica	Frantz	/Mother		6727	' G1	en A	lbin	Rd. I	a Pl	Lata,	Md.	20646
ury or oth			3 □Removel from St	eta	Place of Dispos cemetery, crem cred H	netory or	other plea	e)	1/07		Bushw		
any inj	21. Signeture	Funerel Service L	icensee	mo	22. A	Name a	ART -	ECHOL	S FUN	IERAI	HOME	P. A	
physicien and street transit street buriel-transit street Examiner	Immediate Caus disease or cond resulting in deat Sequentially list if any, leading to	ition h)	a	Dua to	ONAL ASPH (or as a consequence or as a consequence)	uence of)							
of the amending prysical stacks of the purification of the purific	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or es a consequence of):  Due to (or as a consequence of):												
tached to	Part II. Other sig	nificant condition	s contributing to dea	th but not re	sulting in the un	nderlying	cause giv	en in Pert I.	2:	3b. Did tol	bacco use cor	ntribute to	the cause of d
be detach by Phy										1□ Ye	s 2 No	3 Prot	pebly 400Uni
2 should			(						_ 24	la. Was an parlorm	autopsy ned?	ava	era autopsy findi ailable prior to mpletion of caus death?
Pege Com	S AND									1 Ye	s 2 No	19	Yes 2 No
rector, per	25. Was case re examiner?	farred to medical						26. Placa of	Death (Chec	ck only one	a)		
To To	XX Yes 2				SER/Outpatien			4 LI NUISIN	-		nce 8 Oth		1)
ctor: After thy the funeral fication:	27. Manner of De	5 Pending	28a. Dete of (Month,	Day Year)	28b. Time of Injury	A	28c. Injur				w injury occurr		
the the	2 🖾 Accident	t investige 6 ☐ Could no		-	Found:6:			Yes 2 🖾 No			LED ONTO		I Pouto Number
To the Funeral Director: After to completely filled in by the funeral Medical Certification:	4 Homicid	le detarmin	ned 28e. Place of building	RESIDEN					LaP1	ata, M	d.		N ALBIN F
pletaly fill edical	29a. Cartifier (Check only one)	1 Certifying	Physician: To the b xaminer: On the bas	is of axamin	owledge, daath ation and/or inv	occurred estigation	at the tin	ne, date end pl pinion, deeth o	ace, and du occurred at the	a to the ca ne tima, de	use(s) and ma ite and place, a	innar as st and due to	ated. tha causa(s)
\$ d &		nd title of certifier	end manna	AK		29	c. Licens	e number		29	d. Dete signer	d (Month,	Dey, Year)
2 00	29b. Signeture and title of certifier 29k						0.0	M.E			29c. License number 29d. Dete signed (Month, Dey, Year) O.C.M.E JAN. 4, 199		
1000			1/1 1	1 1	The state of the s			9 - 1 - 2		1	U		.,
To the comple	30. Nama end ad		to completed cause	of dead (II)	m 22al Yype 1	Print)		t, Bal	timore	, Mai			

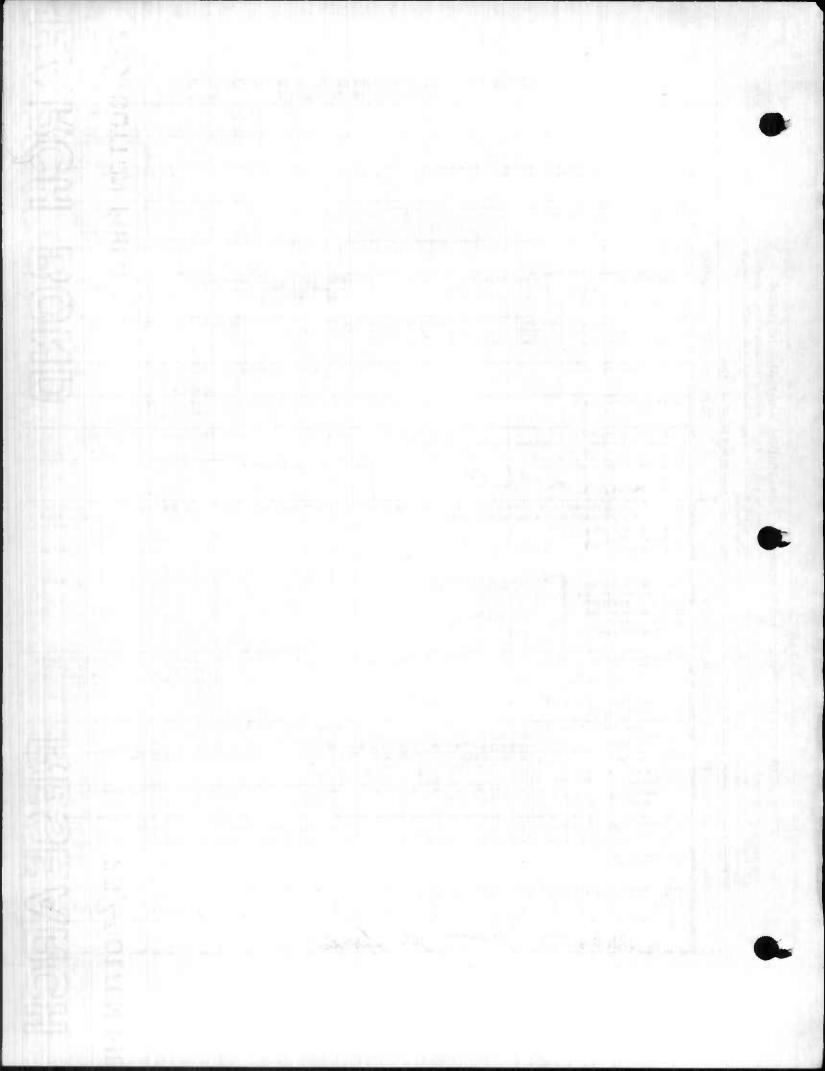


BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hypiene prior to burial, cremation, or removal.	he medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE MOSPITAL, DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within mours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /		OF HEALTH AND	MENTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) Mary Gamson				2. DATE OF DEATH MONTH DAY January 2	1999	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 217–56–3971	5. SEX   6. AGE (In yrs. last	YRS. MONTHS	DAYS HOURS MIN.		2 Penns	ACE (State or Foreign Sylvania
TOR	sa. FACILITY NAME (If not institution, give st Continuum Car		96. CITY	Sykesvill		Carro	
DIRECTOR	10a. STATE 10b. COUNTY	Carroll	10c. CITY, TOWN	Sykesville			DI. INSIDE CITY LIMITS?
JAL [	10e. STREET AND NUMBER			10f. ZIP CODE		CITIZEN OF WHA	
BY FUNERAL	7309 Second Ave:  11. MARITAL STATUS  1 X Never Merried 2 Merried  3 Widowed 4 Divorced	TUC  12. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 ☐ YES 2 ☑ N  IF YES, GIVE WAR OR DATES	0	2178 WAS DECENDENT OF HISPAI If yes, specify Cuben, Maxica 1 VES 2 NO Specifi	NIC ORIGIN? (Specify Yes or No- an, Puerto Rican, stc.)	U.S.A.  14. RACE — Black, V Specify:	- American Indian, White, aic. White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 'Unisnown	completed) (Gh	DEDENT'S USUAL OF kind of work done Do NOT use relired.)  Unknow	during most of working	166. KIND OF BUSINESS	INDUSTRY	1
BE COM	17. FATHER'S NAME (First, Middle, Lest) Lynn Garri	son	OTRTIOW		ME (First, Middle, Meiden Surnem Unknown	•)	Fig
TO B	196. INFORMANT'S NAME (Type/Print) Continuum Care	(Informant)			Route Number, City or Town, State, Sykesveille,		784
	20e. METHOD OF DISPOSITION 1V Burial 2 Cremation 3 Remo	20b. PLACEA cemetery, crer	ND DATE OF DISPOS	Cemetery	1/5/99 Syke	- City or Town	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE / DA	22. H	NAME AND ADDRESS OF FA	AL HOME & CHAP AD 21784 (410)		
CERTIFICATION	23. PART I. Enter the diseases, or on shock, or heart failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSECUTE.)	QUENCE OF):	the mode of dying, euc	th se cerdisc or respiratory	arreat,	Approximate interval Between Onset and Death
PHYSICIAN: MEDICAL C	PART II. Other algorificent condition Claberes Congestiv	e contributing to doesn but not respect to the contribution of the	re	nderlying ceuse given in	Part I. 24a. WAS AN AUTOP PERFORMED?  1 VES 2 MO	A C	FRE AUTOPSY FINDINGS MAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?  YES 2 NO
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO	HOSPITAL: 1   Inpatient 2   ER/Outpatient 3	OTHE	26. PLACE OF DEATH (C/ R: sing Home 5 - Residence			
ву Рну	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	28c. INJURY AT WORK?  1 YES 2 NO	28d. DESCRIBE HOW INJURY		
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At her building, etc. (Specify)	ne, farm, street, fac	lory, offica	28f. LOCATION (Street and Nun City or Town, State)	aber or Rural Rou	te Number,
COMPLETED	ann)	CIAN: To the bast of my knowledge, dea R: On the basis of examination and/or in					nd menner as stated.
BE	29b. SIGNATURE AND TITLE OF CHITTEEN	ignmanms		29c. LICENSE NU 025	00   29d. (	DATE SIGNED (A	forth, Day, Year)
01	30. NAME AND ADDRESS OF PERSON WHITE ADDRESS OF PERSON	RUN BIVO OU 32. REGISTRAR'S SIGNATURE	UINGS /	Mills MO	21117 JA	y Lip	pman, MD
	JAN 0 4 1999	Beneva	O. Sp.	als		0	





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death <sup>9</sup>, 1999 Physician John Howard Hettinger January 2100 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Carroll Westminster If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Stete or Foreign Country)
June 13, 1922 Pennsylvania 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (Stete or Foreign Country) **Funeral** Months M 2DF Deys 169-18-6026 76 Director **Usual Residence of Decedent** 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Carroll Sykesville 1 ☐ Yes X ☐ No Director 288-6 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23s or 1607 Arrington Road 21784 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 DX'es 2 DNo
M Yes, Give
Yeer or Detes: WWI Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White ğ WWII 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: if them 27 is marked other tha any Injury or other tree Heavy Equipment Operator Construction 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Hettinger Lillie Mohn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Blanche Hettinger (Wife) 1607 Arrington Road Sykesville, MD 21784 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete N☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 1/5/99 Sykesville, MD Springfield Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility HAIGHT FUNERAL HOME & CHAPEL (Box 195) nan Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Finet disease or condition resulting in death) /Medical · Pulmonary Edema 30 Min Examiner Physician/Medical Examiner physician and s the burlal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Pancreas Records, P.O. Box 68760 · Metastatic Cancer Due to (or es e consequence of) 080 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4₽ Onknown Heart Failure by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? this certificate has 1 Yes 2 No 1 Yes 2 No Division of Vital To the Mospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 1 3 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 29a, Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MY

State Registrar

JAN 0 4 1999 DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

Herbert

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

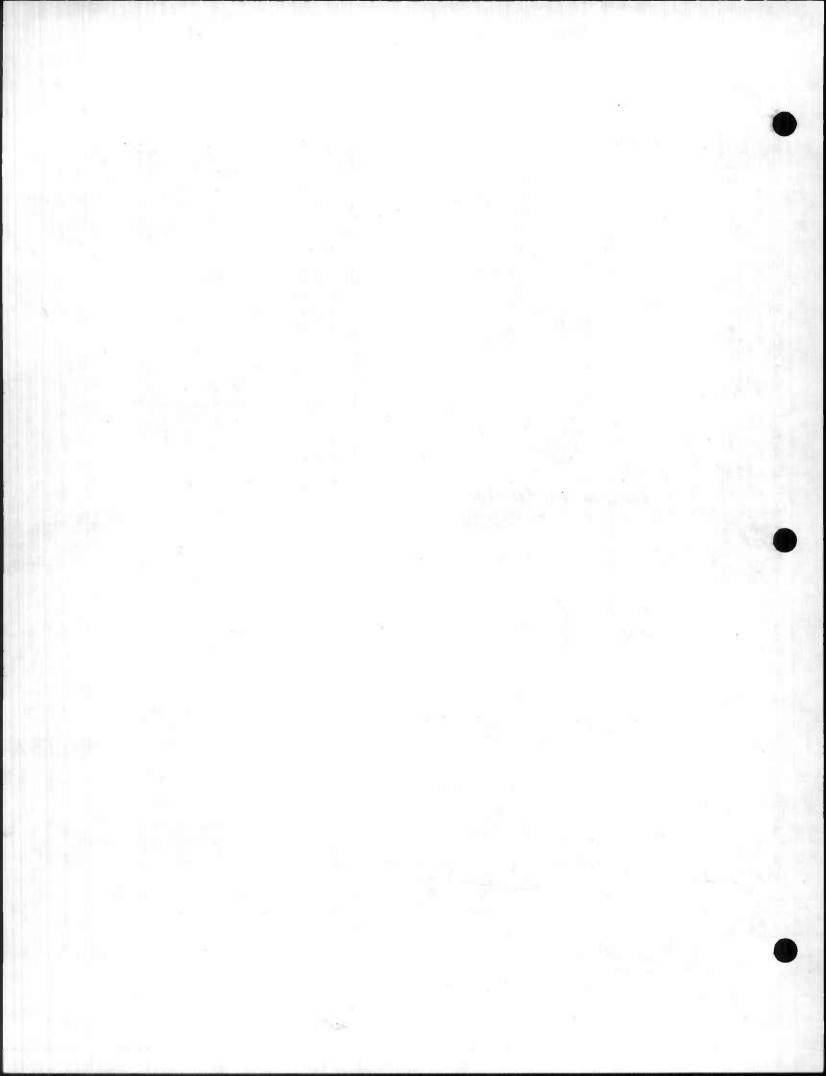
MD

32. Registrer's Signature

P. Henderson J.

000 519 24

295 Stoner Aux Suitz 307 Westminster MN

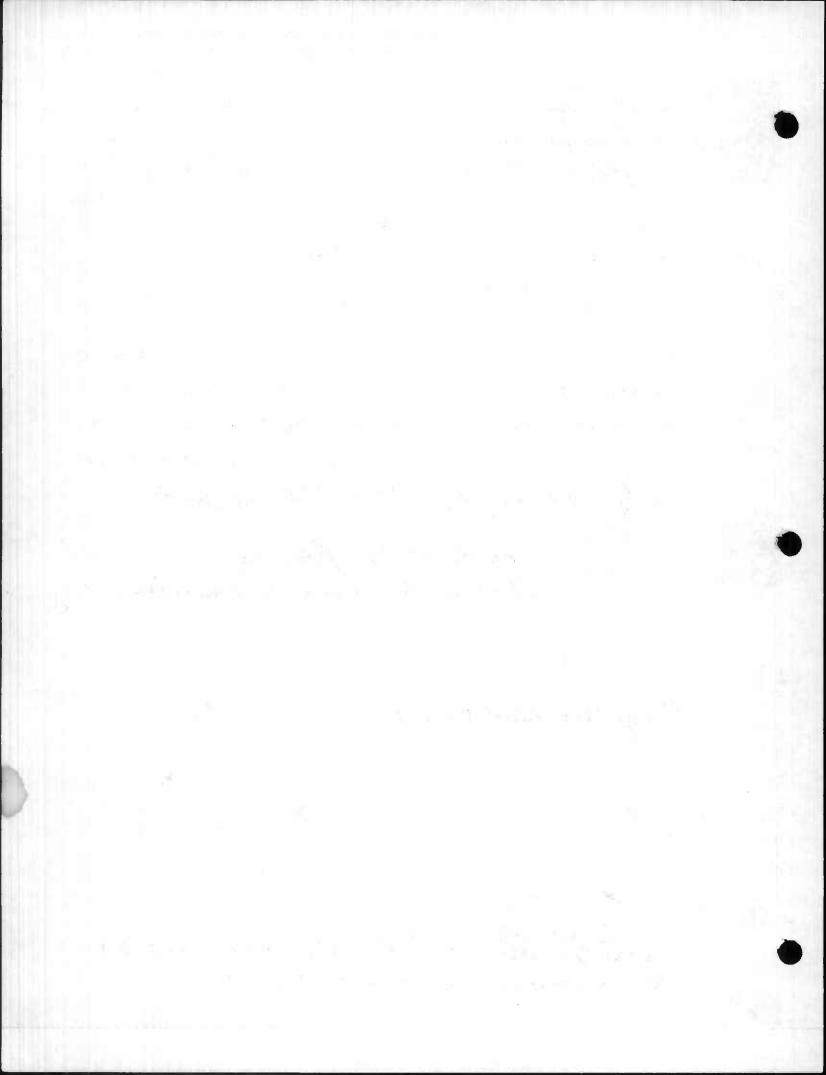


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death **Physician** Month Evelyn Gertrude Hobbs Jan 06 1999 5:30 pm /Medical 4e. Fecility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shore Nursing & Rehab Center Caroline Denton If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Ye March 25 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (Stata or Foraign Country) **Funeral** Deys Months Hours 1 □ M 2 1 F 90 Yrs. 214-18-4217 1908 Director Maryland Usuai Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be nothed at 10d. inside City Limits 1 N Yes 2 No Director Maryland Caroline Ridgely 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be liled within 72 hours after death a Department of Heelth end Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a eny Injury or other traumatic event, the Medical Examines mains ance. P.O. Box 413 21660 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highast greda complated) 16a. Decedent's Usuai Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 7yrs manufacturing seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumeme) James Henry Hobbs Mary Frances Cahall Hobbs 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) LeRoy Hobbs, Sr./ brother 29400 Stoney Ridge Circle Easton, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Nama of cametary, cramatory or other place) 20c. Location - City or Town, State 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State 1/10 4 ☐ Donation 5 ☐ Other (Specify) Church Hill Cemetery Church Hill, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Fleegle & Helfenbein Funeral Home, PA Greensboro, Maryland 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between Onset and Death **Physician** immedlete Cause (Final disease or condition resulting In death) /Medical Examiner Physician/Medical Examiner ettending physician end for use as the buriel-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that leitled excepts.) Box 68760. thet initiated events resulting in death) Lest Due to (or es e consequence of) USB. P.O. | Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24e. Wes an eutopsy performed? 1 ☐ Yes 1 □ Yes 2 □ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only ona) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Hospital: 1 ☐ inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Deeth Netural 28a. Date of injury (Month, Day Year) 28d. Describe how Injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, offica building, etc. (Specify) 281. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide the certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end manner as steted.

| Madical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29e. Certifier (Check only 29b. Signeture and take of portific 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name ano pleted cause of deeth (Item 23a) (Type, Print) S. Washington 57 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar



Melvi	n Isle	ey ITEMS: #23 PART I, 2	State of Maryla 7, 28A-F PER MEO (	nd / <b>Dep</b>	artment o	of Health and of Death	d Mental Hy	giene 9 9	3 00	871
		1. Decedent's Nama (First, Middle, I	•				2. Data of De	ath		. Tima of Death
P	hysician /Medical	MELVIN ISLEY					Januar	Day V 08. 1	Yaar 999	8:50 P.M.
E	Examiner	4a Facility Name (If not institution, g	ive street and number)			4b. City, Town,	or Location of Deat			
		Maryland Correc	tional Trainin	g Cente	er	Hagerst		Was	hington	n
Fı	uneral	A CONTRACTOR OF THE PARTY OF TH	72	s. last birthday	If Under 1 \    Months   D		Hrs. 8. Data of Bir Min. Month Do	th L. Year)	9. Birthplace	a (Stata or Foraign
Di	rector	213-04-7721	<b>X</b> □M 2□F 28	Yrs.			10-2/-	70	WASHIN	GTON, DC
pue	1	Usual Residence of Decedent  10a. Stata 10b. County	10c. C	City, Town or L	ocation				10d.	Inside City Limits
Aany	and and or			r. WASH						X Yas 2 No
the	in 23e or 28e-f sho if must be notified at neral Director	10e. Street and Number	GEORGES F1	L. WASH	10f. Zip Co	vle		10g. Citizen of	What Country?	)
with	0 0									
-Cast	Pa 20	9405 SANDY CREEK	12. Was Decedent Ever in 0	U.S. 13.		744 t of Hispenic Origin	(Specify Yes or No	UNITED	STATES ce - Amarican I	
72 hours after death with the Maryland	at, or hame 23 Example: mark by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify  1☐ Yas 2☐	Cuban, Mexican, P	uarto Rican, atc.)	Bla	ck, Whita, atc. y: BLACK	
ا ا	P P	15. Decedent's		16a. Dece	dent's Usual C	Occupetion		16b. Kind of B	usinass/Indust	iry
within 7 ans.	r, the Kedice Completed	(Specify only highest g	College (1-4or 5+)	lifa.	DO NOT use	lone during most of retired)	working			
Men	omp		1	LA	NDSCAPI	ER	, Europa	PR:	IVATE	
tel Hygi	25 0	17. Father's Name (First, Middle, Las	at)			18. Mothar's	Nama (First, Middla	, Maidan Sumar	na)	
Men	5 5 C	JAMES T. ISLEY				JACQU:	ELINE MUR	RAY		
Pue	E	19a. Informant's Name/Relationship		19b. Mail	ing Addrass (S	treet and Number o	r Rural Routa Numb	er, City or Town	, Stata, Zip Co	da)
and die	other tr	JACQUELINE ISLEY				CREEK RD				
nant of H		20a. Method of Disposition  1 2 Greenation 3  4 Donation 5 Other (Spec	Removal from State	cemetary, cre	osition (Nama ematory or othe MEMOR L		Data 1-16-99	LANDOVI		Stata
Depart.	important: If any injury or page.	21. Signature of Fuencel Service Lio	Pach			ALEXANDER NN. AVE S				
/Me	sician edical miner	23a. Part1. Enter the same of co- shock, or heart failure. List on Immediata Cause (Final disease or condition resulting in death)	BLUNT FORCE		ES OF HE				Or	arval Batween set and Death
ate be executed	physician and the burlatransit dical Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury	Due to (	(or as a conse	equence of):					
cartifi		that initiated events resulting in death) Last								
deeth	ic atta	Part fl. Other significant conditions	contribution to death but not re	eulting in the	underhine caus	e airen in Part I	23h Did	tohacco usa co	patribute to the	e cause of death?
that the	igned by the stranding be detached for use a by Physician/M	ratii. Suur agimean connuons	contracting to death but not re-	isoning in the	uncertying Caus	o great in Part I.		Yes 2□ No	3 Probeb	
law requi	2 should 2 should pleted							an autopsy ormed?	availa	autopsy findings ble prior to etion of cause th?
Ē.	Page Po						10	Yas 2□No	104	as 2 No
cian	director, page Co	25. Was case referred to medical examiner?				26. Placa ot	Death (Check only	ona)		
Σ.	9 0	161 Yes 2□ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other: 4 Nursin	ng Homa 5□ Ras	idence 6 QOtt	nar (Specify)	t scene
		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Data of Injury (Month, Day Year)	28b. Tima o Injury	of P 28c.	Injury at Work?	28d. Describe	how injury occur	rred	
Attanding r death.	ed in by the funer Certification:	2 Accident investigati	1 0 00	6:50	М	1 Yas 2 No	SUBJECT	WAS ASSAL	JLTED	
	Till by	3 ☐ Suicide 6 ☐ Could not detarmine		homa, farm, st	treet, factory, o	ffice	28f. Location City or To	(Street and Numi wn, Stata) MAF	ber or Rural Ro RYLAND CO	outa Number, ORRECTIONAL
irs aft	2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			L CELL			TRAINING		HAGERST	
n 24 hours	To the Funeral Direct completely filled in by Medical Certifi		hysician: To the best of my kn miner: On the basis of axamin and manner stated.							
To the within 2	To To To To To To To To To To To To To T	29b, Signature and title of certifier	tanen, M.	1	29c. L	O.C.M.	Ε.	29d. Date signe January		
		30. Name and address of person who	pestane (	om 23a) (Type		nn Street	Raltimo	no Mar	vland 2	1201

State Registrar

62. Registrar's Signature

Her S L MAL

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ian ical iner	Burton Andr									_		. Tima of Death
	Bul ton Andl	ew Jack	son,	Jr.				7	Month	Day 0 7	Year 1999	12:50 PM
	4a. Facility Nama (If not institution, g						4b. City, Town			4c. County		
	Dorchester Ge		-		411			bric			orches	
	214-07-0107	Sax 7	. Aga (In yrs	last birthday) 4 Yrs.	If Unde Months			Min.	Data of Birth (Month, Day, 1ay 26,	1914	9. Birthplace Country) Mary	(State or Foreign
	Usual Rasidance of Decedant  10a. Stata  10b. County		10c. C	ty, Town or Lo	cation						10d.	Inside City Limits
tor	Maryland Dorc	hester			Fish	nin	g Cree	k				1 ☐ Yas 2 No
Director	10e. Street and Number					lp Cod			10	791-	What Country?	
	1222 Horse Po						634			U.S.A		
by Funeral	11. Maritai Status  1 ☐ Nevar Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 X Yas 2 If Yas, Giva Yaar or Dat	as? ! □ No		Was Dece f Yas, spi 1 ☐ Yas	ecity C	of Hispanic Origin uban, Maxican, I No Specify:	n? (Speci Puarto Ric	y Yas or No- can, atc.)		e - Amarican I ck, Whita, atc. Whi	
Ped	15. Decedent's E	Education		16a Deced	dant's Usu	ual Oc	cupation	éadelaa	1	6b. Kind of Br	usinass/Indust	
Completed	(Specify only highast gi Elemantary/Secondary (0-12)	Coilaga (1-4	for 5+)	lifa.	DO NOT	use ret	na during most o lired)	r working				
ပိ	17. Fathar's Nama (First, Middle, Las	Al		Wat	erma	an	40.84-15-1	Alama //	First, Middle, M		ellfis	h
Be	Burton Andre	•	on, S	ir.			18. Mothars		nes Hu		na)	
2	19a. Informant's Name/Ralationship				ng Addras	ss (Stre	eet and Number				Stata, Zip Coo	de)
	Joy A. Jackson,				3 Fi	irs	t St.,	Cam	bridg	e, MD	21613	3
	20a. Mathod of Disposition  Burial 2 Cramation 3	Damovai from Si		Place of Dispo	sition (Na natory or	ama of other	olace)		Data 2	Oc. Location -	City or Town,	State
	4 □ Donation 5 □ Other (Spec						emeter	y 1-	11-99	Hur.	lock,	MD
	21. Signature of Funeral Service Lice	-					drass of Facility Bromwe	11 5	unora	l Home	D D 7	
	23a. Part 1. Enter the disease or cor shock, or heart failure. List only	oed-102	mu	veel3	08 F	lig	h St.,	Can	bridg	e, MD	21613	•
	shock, or haart failure. List only	nplications that cal ona causa on aa	ch lina.	tn. Do not ent	ar tha mo	oda or c	dying, such as ca	irdiac or r	aspiratory arra	St,	inte	proximata arval Between set and Death
	Immediata Causa (Final disaasa or condition		6	つかと	8h	nc-	16					6 bons
	rasulting in death)	a	Dua to (	or as a consec	uance of	):						6 hans
iner		h	Bila	tero	-	PI	leaven	ici			(	e hours
Examiner	Sequentially list conditions, if any, leading to immediate		Dua to (	or as a conseq	uance of)	·):						
dical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c	B	P	41						i	
1 W I	rasulting in death) Last		Dua to (	or as a conseq	uance or)	):					Ī	
an		d									i	
Physician/M	Part II. Other significant conditions	contributing to dea	th but not ras	sulting in the u	ndaifying	causa	givan in Part I.		23b. Did tol	pacco use co	ntribute to the	cause of death
									1 □ Ye	8 2 No	3 Probabl	y 4 Unknow
d by								-	24a. Was ar	autopsy	24b. Wara	utopsy findings
Completed		7-10-							perform	led?		ole prior to etion of causa th?
mo									1 ☐ Ya	s 2 No	1 🗆 Ya	is 210 No
Bec	25. Was casa rafarred to medical axaminar?						28. Placa o	f Death (	Check only one	)		
2	1 ☐ Yas 2 ☐ No			ER/Outpatier		NOA			5 🗆 Resida			
ion:	27. Mannar of Death  1 Natural 5 Panding		Injury Day Year)	28b. Tima of Injury	м	28c. lr	njury at Vork? □Yas 2□No		d. Dascribe ho	w Injury occur	red	
Certification:	2 Accident Investigation 3 Suicide 6 Could not determined	28a. Piaca o	f Injury - At h	oma, farm, str fy)					Location (Str City or Town	eet and Numb Stata)	per or Rural Ro	uta Number,
edical C	29a. Cartifiar 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the b miner: On the bas and manne	is of axamina	owiedga, daath ation and/or inv	occurred atlgation	d at the	tima, data and j y opinion, daath	place, and	dua to the ca at the time, de	use(s) and ma ta and place,	annar aa state and dua to tha	i. cause(s)
Me	29b. Signatura and titla of cartifor	1	۸		29	9c. Lice	ensa number		29		d (Month, Day	Year)
	Jankley	My Mi	)			ク	4752	4		1-9-	-99	
1	30. Nama and addrass of person who	complated causa	of daath (Ita	m 23a) (Type,	Print)			•				

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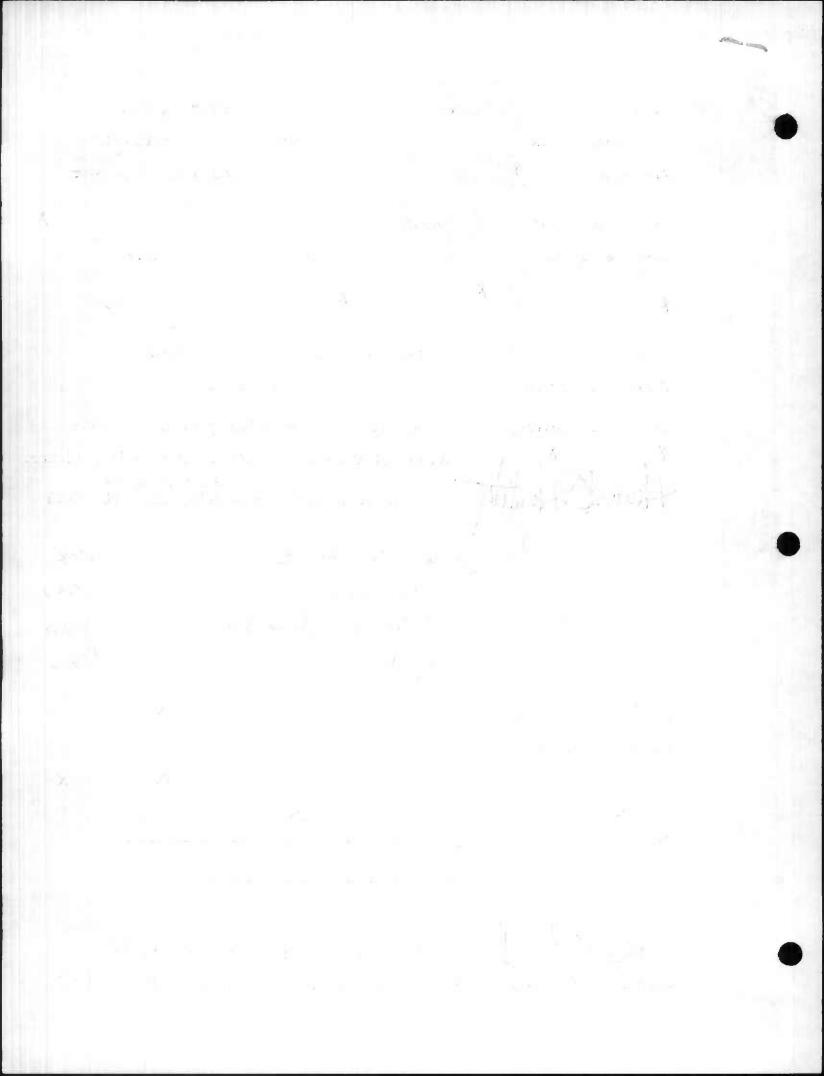
5.0

Judge & wash profession

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Death **Physician** Month January Hulda Jones /Medical 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Dorchester Hall Nursing Home Hurlock If Under 1 Months 5. Sociel Security Number If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Day, Year) 7/28/1911 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Yrs Delaware 87 171-10-6261 Director Usual Residence of Deceden 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show If is marked other than "natural", or itema 23e or 28a-f shor traumatic event, the Medical Exponent mast be notified as 1 ☐ Yes 2 📉 No Director MD Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. permit. Pages 1 and 2 should be filed within 72 hours effer death a Department of Health and Meniel Hygiere. important: If item 27 is marked other than "natural", or itema 23e any injury or other traumatic event, the Medical Examiner mass 2006. 5174 Wesley Road 21643 Funeral 12. Wes Decedent Ever in U,S Armed Forces? 14. Rece - American Indien, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Pay Roll Clerk Foundry 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Willey Nora H. Philip A. Cannon 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 324 Nicholson Road - Ridley Park, PA Elnora C. Whiteley 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 1 Buriel 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) 1/4/99 Bridgeville, Delaware Bridgeville Cemetery 21. Signeture of Funerel 22. Name end Address of Fecility 202 Laws Street Hardesty Funeral Home-Bridgeville, DE 19933 23a. Pert1. Enter the disease, or complications thef caus shock, or heart feilure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medicai Examiner to (or es e consequence of) Physician/Medical Examiner the attending physician and shed for use es the bunel-transit The law requires that the death certificete be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or infury that initiated events resulting In deeth) Lest Due to (or es e consequence of): Box 68760, Due to (or as e consequence of): Division of Vital Records, P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco usa contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveileble prior to completion of cause of deeth? Completed 24e. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Alursing Home 5 Residence 6 Other (Specify) To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menper of Deeth 28c. fnjury at Work? 28d. Describe how injury occurred within 24 hours efter death.

To the Funeral Director: After t
complately filled in by the funera Certification: 1 Neturel 2 ☐ Accident 5 Pending investigation 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29e. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DELHAR 32. Registrer's Signeture Year) State 5 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene (

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Rhae Louise Keadle JANUARY 03, 1999 11:30PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 3, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 214-09-1414 Yrs. 80 Director 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits or 28a-f show Maryland Washington Maugansville 11 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14013 Maugansville Road natural, or items 23s. 21767 USA Funeral 14. Race - American Indian, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 ☐ Yas 2 No If Yes, Give Year or Datea: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: White Specify. þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry filed within 72 Hyglens. other than Elementary/Secondary (0-12) College (1-4or 5+) homemaker home 18. Mothar's Nama (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked othar any injury or other trearmatic event once. 17. Father's Name (First, Middla, Last) Be Clyde Orval Moringstar Orpha Grace Glessner 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon K. Frey 1305 The Terrace Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

Rest Haven Cemetery

20c. Location - City or Town, State 1/7/99 Hagerstown, Maryland

21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. ahock, or heart taiture. List only one cause on each line.

22. Name and Address of Facility Gerald N. Minnich Funeral Home

Do not enter the mode of dying, such as cardiac o

305 N. Potomac Street Hagerstown, Maryland 21740 raspiratory arrest, Approximate

Immediate Cause (Final disease or condition resulting in death)

**Physician** /Medical

Examiner

physician and s the burial-transit

USB 88 attending p

bengis teb ed b

page 2 has

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i

The law requires that the death certificate be executed

Box 68760,

Records, P.O.

Division of Vitai

Rhae Louise KEADLE

Examiner

Physician/Medical

þ

Completed

Be

10

Certification:

Medicai

3 Suicide

4 Homicide

ACUTE BRONCHOPNEUMONIA Dua to (or as a consequence of):

6 DAYS MANY

YEARS

Intarval Batween Onset and Death

Sequentially list conditions, if any, teading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

DEMENTIA OF ALZHEIMER'S TYPE Due to (or as a consequence of):

Due to (or as a consequence of):

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1 Yea 2 No 3 Probably 49 Unknown

TRANSIENT ISCHEMIC ATTACKS

CONTRACTURES OF EXTREMITIES

24a. Was an autopsy performed?

2 No

24b. Were autopsy tindings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was casa reterred to medical examinar?

26. Place of Death (Check only ona) Other: 45 Nursing Homa 5 Rasidence 6 Other (Specify)

1 Yas 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27, Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending 2 Accident investigation

Hospital:

28c. Injury at Work? 1 Yas 2 No

28d. Describe how injury occurred

1 Yes

28e. Place of tnjury - At home, tarm, street, tactory, office building, atc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

January 04, 1999

29b. Signature and title of certifier

6 Could not be datarmined

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

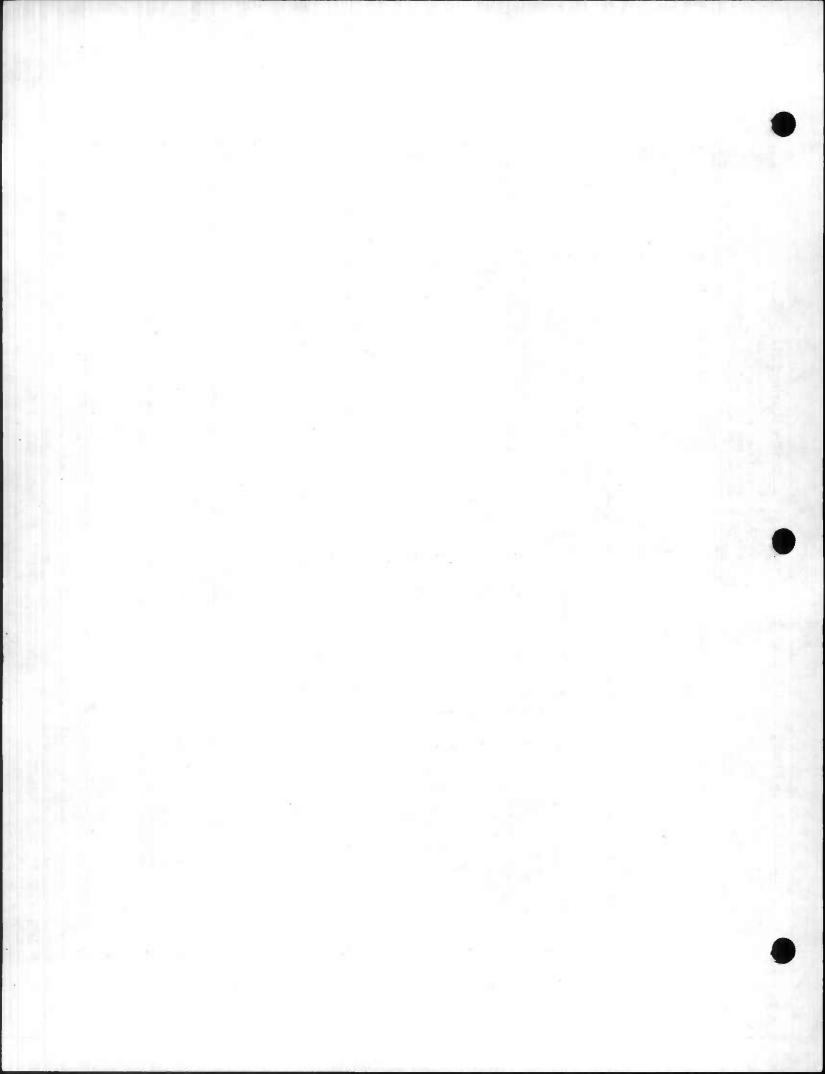
30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

Edson Moody M.D. 1190 Mt. Aetna Rd. Hagerstown, 21740

State Registrar

31. Date filed (Month, Day, Year) JAN 05 32. Registrar's Signatura

D07857

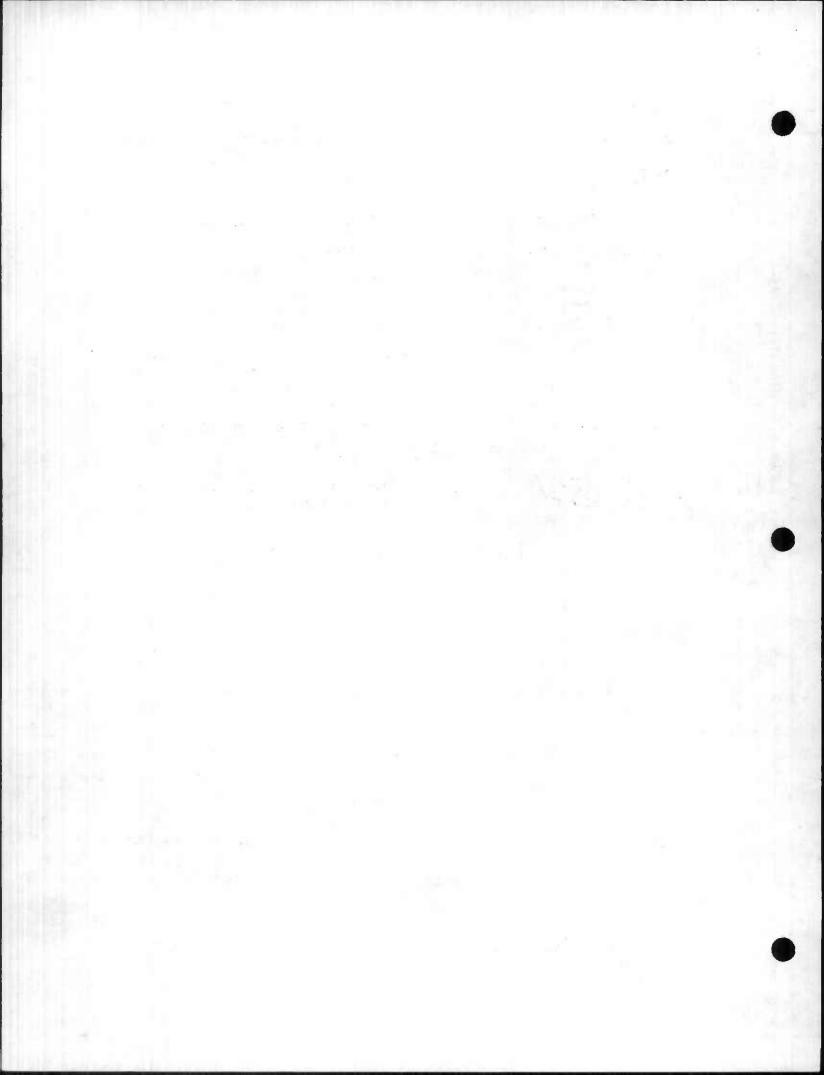


State of Maryland / Department of Health and Mental Hygiene 0 0 0 7 5

para King		otato or many ta	Certi	ficate of	Death	В	leg. No.	UUG	5/5				
	1. Decedent's Nama (First, Middla, Last)					2. Date of Dea	th		Fime of Death				
Physicial	Davelane I Vine					January	Day 01, 19	999 2:	40 A.M.				
/Medica Examine	4 - 6 - 104 - 51	treet and number)			4b. City, Town, or		4c. County						
	Memorial Hospital				Cumberla	and	Allec	gany					
Funeral	Social Security Number			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day			State or Foreign				
Director	169-38-5471	M 2√2 F	47 Yrs.	Worling Duys	Tiodis IVIII.	11/11/		PA					
2	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Loca	tion				10d. In	side City Limits				
h the Maryland or 28a-f show a notified at					Ctront	31 1 1			Dyes 2 □ No				
1284 Inotific	PA Franklin	1 12	23 SOULII	10f. Zip Code	Street, (		ourg log. Citizen of V	Whai Country?					
2 4 4		St.		17	201		USA						
or deall hems 2 ner.ms	11. Marilal Status 1  120 Nevar Married 2 Married	2. Was Decedani Evar in U	J,S. 13. Wa		Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No-	14. Rac	e - American Inc	dian,				
020	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yas 2X No If Yes, Give Yaar or Datas:		es, speciny Cub Yes 2√∏tNo		o Hican, etc.)		ck, Whita, etc.  White					
5-0 72 ho	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	ation completed)	16a. Deceder	nt's Usual Occup	pation during most of wo	rkina	16b. Kind of Bu	usiness/Industry					
15 mm 151	Elementary/Secondary (0-12)	College (1-4or 5+)			one during most of working otherwise stired)								
d 2			Cash	ier	T 40 14 14 14 14 14	To delicate the state of the st		tment St	ore				
Band done	17. Father's Name (First, Middle, Last)  Robert R. Cullum	2				ne (First, Middle,	maioen Suman	ne)					
Ly division in the country of the co	19a. Informant's Name/Relationship (Typ	-	10h Mailine	Address (Class)	and Number or Ri	Kline	Chros Town	Otata Zin Code					
Ma d 2 s 7 ls an				School of the Control					,				
	Naomi L. Ricker  20a. Method of Disposition	20b	Place of Disposit	ion (Name of	le Road,			City or Town, S	tate				
Pages nert of mt: if th	1\( \text{Lincoln Cemetery} \)   1\( \text{Specify} \)												
Baltimore, semit. Pages 1 as Department of Hea mportant: If Hean in y Injury or other adds.	21. Signatura of Funeral Service License	of .	22. N	lama and Addre	ess of Facility				IA				
W FOLLS	X-1 PLL		TI	nomas L.	. Geisel	Funeral	Home, I	Inc.					
	23 Pm1 Enter the disease, or complic	cations that caused the dea	ing Sprin	c or respiratory arr	hambers est	burg, P	A 17201 oximate						
Physician	333 Falling Spring, Rd. Chambersburg, Shock, or heart failure. List only one cause on each line.												
/Medical	Immediate Cause (Final disease or condition  West Pic Taylyws												
Examiner	rasulting in death)	1											
Z ~	,												
68760, ificata be executed physician and as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying.	Due to (	e to (or as a consequence of):										
68760, ifficata be exe g physician a as the burial-													
587 licata physicata	Cause (Disease or injury that initiated events resulting in death) Last	Dua to (											
	d.												
.O. Box the death cer by the attendir	d.  Part II. Other algnificant conditions cont	ributing to death but not re-	sulting in the und	ertvino cause or	ven in Part I.	23b. Did to	obacco use co	ntribute to the	cause of death?				
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E A 0													
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law n law n law n las be								of death	ion of cause				
The la						150	es 2 No	t Dires	2□ No				
of Vital Re- Physician: The lav- this certificate has ral director, page 2	25. Was case referred to medical			1 -		ath (Check only or	ne)						
hy his	1 1 1 1 No		ER/Outpatient	3LI DOA		fome 5 ☐ Resid							
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Or Al after Direction by	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ify)	t, ractory, office		City or Tow	n, State)						
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Hoa Pun Fun etaly	(Check only 2 Medical Examine one)	er: On the basis of examinand manner stated.											
To the within To the comple	29b. Signature and title of certifier	1, -	29c. Licens	se number	3	29d. Date signe	ed (Month, Day,	Year)					
F > F 0	Malline mo	Male		0.	O.C.M.E. January 02, 1999				99				
	30. Name and address of person who com												
		KOREU MM)			Street, B	altimore	, Maryl	and 212	01				
State	31. Date filed (Month, Day, Year) 1999	32. Registrar's Sign		1									
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Registrar



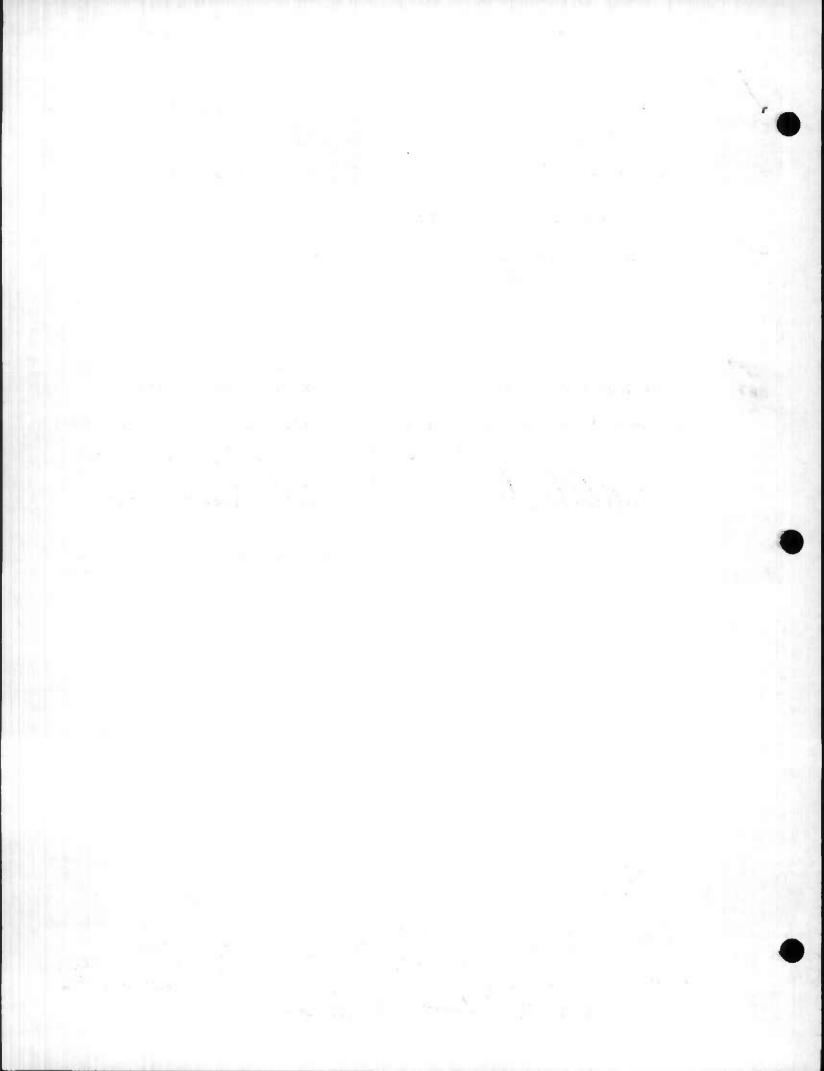
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Į.	Physician	1. Decedent's Neme (First, Middle, Las Robert Lee Ke	rns				2. Date of De Month JAN	Dey 7, 1999	Year	3. Time of Death 1726 PM
	/Medical Examiner	4a Fecility Name (M not institution, give				4b. City, Town, or		h 4c. County	of Deeth	EORGES
	Funeral Director	5. Social Security Number 6. Se	7. Age (In	yrs. lest birthday).	If Under 1 Year Months Days	I_AUREL If Under 24 Hrs Hours Min.	(Month, Da	th	9. Birthpi Coun	lace (Stete or Foreign
	with the Maryland a or 284-f show the notified at Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G		c.City.Town or Loc Beltsvill					10	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	vith the Ma t or 28e-f a he notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \		
050	death irms 23 irms ners	4507 Josephine Av  11. Marital Status  1 Never Married 2 Married  3 Nidowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		20705 Ves Decedent of HYes, apecify Cub	lispanic Origin? (S an, Mexican, Puerl Specify:		- 14. Rad Bled	d States of Americ Race-American Indian, Black, White, etc.  Pocify: White	
Maryland 21215-0020	within the or	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	college (1-4or 5+)	16a. Deced (Give) iiie. D		nation during most of wo d)	rking	16b. Kind of B		outractor Co
yland	2 should be filed within end Mentel thyglene. Is marked other than eumatic avent, the TO Be Compi	17. Father's Name (First, Middle, Last) Walter Lee Kerns				Linda Ha				
re, Mar	is 1 and 2 sh if Health end item 27 is m other treum	19a. Informant's Name/Relationship (7 Linda R. Kerns – 20a. Method of Disposition	Mother 2	4507 Ob. Place of Dispos	Josephin	Ţ			lary1a	and 20705
Baltlmore,	permit. Pages 1 and 2 should be filed Department of Health and Mentel Hyg Department of Health and Mentel debter important; if Nem 27 is merked other eny injury or other treumatic avent, page.  To Be C.	1 Burial 2 A Cremetion 3 4 Donation 5 Other (Specify  21. Signature of Funeral Service Loan		1/12/99 Home, P.	ria,	Virginia				
	Physician /Medical Examiner	23a. Panis. Enter the disease, or comp shock, or heart laiture. List only of transdiate Cause (Finet disease or condition resulting in death)		death. Do not ente	cardinate of dyle		c or respiretory e	yattsvij	ITE, N	Approximete Interval Between Onsel and Death
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Box	ath certifor use		d							
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Records,	> 44 44							an autopsy ormed?	ava	ere autopsy findings ailable prior to mpletion of cause death?
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	Physician: The this certificate oral director, pages 1: To Be Co.	25. Wes case referred to medical axaminer?	Hospital:	1mr	_ Ott	Nor-	ath (Check only			
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DIVIS	or Att offer of In by	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, ferm, afre	et, fectory, office		28f. Location ( City or To	Street end Numb wn, Stete)	per or Rure	l Route Number,
	n 24 hours n 24 hours ne Funeral pletsly filled edical C	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exam	e, and due to tha urred at the time,	cause(s) and made end place,	anner as st and due to	ated. the cause(s)				
)	To the Ho within 24 P To the Fu completely	29b. Signature and title of certifier	Chute, no	.C.M.E	29d. Dete signed (Month, Dey, Year)  JAN. 8, 1999					
		30, Name and address of person who o	ompleted cause of death	(Item 23a) (Type, F 111 Penn	Street,	Baltimo	re, Mary	land 21	201	
	State	31. Date filed (Month, Day, Year)	32. Registrar'a S	Signature	1					170

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Physic		1. Decedent's Nama (First, Middle, L		n cr				2. Data of De Month Jan.	Dey 5, 1999	Yeer	3. Time of Death 2:30 pr	
/ /Medi Exami		Alexander Jackson King  4e. Fecility Name (If not institution, give street and number)  4b. City, Town, or									2.30 pr	
		19924 White Ground Rd. Boyds						Montgomery				
Funeral Director		5. Social Security Number 6.  215-53-8453  Usual Residence of Decedent	Sex 7. A									
land and		10e. Stete 10b. County		10c. City, Town or Location					10	d. Inside City Lim		
Mary Fed	to	MD Montgomery Boyds									1 □ Yas 2 ☑	
9 P. P. P. P. P. P. P. P. P. P. P. P. P.	Director	10e. Street and Number		10f. Zip Coda					10g. Citizen of Whet Country?		ry?	
h wit	0	19924 White Ground Rd.			20841				U.S.	Α.		
pomit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28af show any Injury or other traumatic event, tra Madical Exercines must be contract and Dec.	by Funeral	11. Marital Stetus  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dacedant Armed Forcas	as Dacedant Evar In U,S. 13. W med Forcas? If ' ] Yes 2 No /as, Give 10		las Decedent of HispenIc Origin? (Specify Yas or Yes, specify Cuban, Maxican, Puerto Rican, atc.)  Yas 2 Wo Specify:						
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and and maz7		John Stuart Ki	ng/fathe:	r 1	19924 V	White	Ground		oyds, N	ld.	20841	
Deficiency of the pages 1 and popularity of Heal mportant: If item 2 and injury or other pages.		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3	Removei from State	20b. Piece	a of Disposition etery, crematory	(Name of or other ple	De)	Pete, 20c. Location - City or Town, Stete				
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permit. Departminents any Inje		21. Signature of Funeral Service Lioques 22. Name end Address of Facility Hilton Funera										
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this can dire	2	axaminary Hospitei: Other						Home 5 ☐ Residence 6 ☐ Other (Specify)				
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the Hospital the Euners the Funeral npletely filled	edical	29e. Cartiflar (Check only one)  Check only one)										
Matthin To the pomple	Me	29b. Signature end titla of certifier				29c. Licens	e number		29d. Daţa signed (Month, Day, Year)			
17		1 De of	who		M.1)	010	1011 = 0	97 1/7/99				
IN		30. Name and address of person who	completed causa of	Jeath (Itom 23	a) (Type_Print)	010	10403	x 0 1			2031	
2		Jay Gree	1	830	of Ar	lina.	ton BI	ud ac	9 Fai	rfax	Va	
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State of Maryland / Department of Health and Mental	Hygiene
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Certificate of Death Reg. No. 1 Decedent's Nama /First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** 1999 11:40AM January Gregory Ignatius Kirkwood, Sr. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** Talbot The Memorial Hospital Easton If Under 1 Yaar | If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2□ F Yrs. **Director** 213-28-4760 December 7, 1931 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Haaith and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23e or 28e-f ahow any injury or other traumatic event, it a Medical Expriner man be notified. 1 Yes 2 No Directo Maryland Caroline Denton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 300 Kerr Avenue 21629 United States
14. Race - American Indian, Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 Pas 2 No If Yes, Give Year or Dates: 21 yrs. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Caucasian by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elamantary/Secondary (0-12) 12 Major - U.S. Air Force Military Service 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Edward Kirkwood Katherine Elizabeth Wehe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Kerr Avenue, Denton, Maryland 21629 Date 20c. Location - City or Grace D. Kirkwood Wife Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State Maryland Eastern Shore Veterans Cemetery 1/5/99 4 ☐ Donation 5 ☐ Other (Specify) Beulah, Maryland 22. Name and Address of Facility Moore Funeral Home, P.A. 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

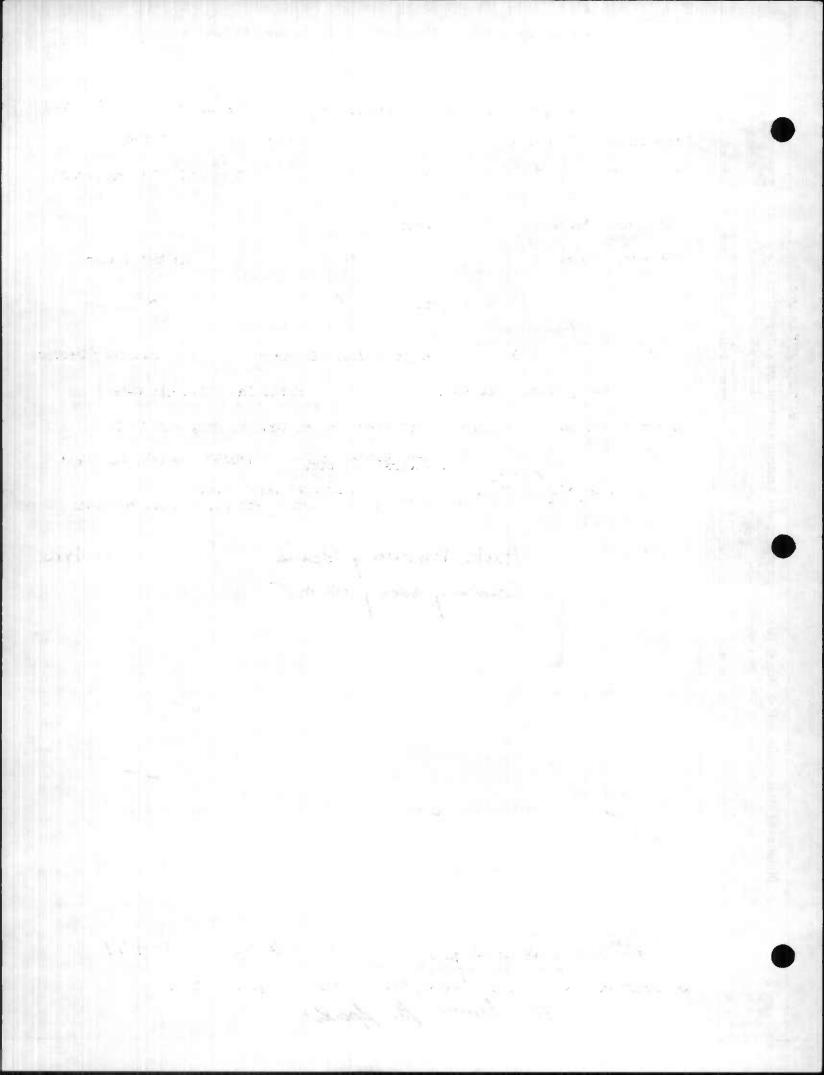
Approximate Approximete Interval Batween Onset and Death **Physician** Immediate Ceuse (Finel disease or condition rasulting in daath) /Medical Pulmonane lyn Examiner Due to (or es e consequenca of): Examiner Coroning Anterior The law requires that the death certificate be assecuted attending physician and for usa as tha bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. tha signed by t d be datach 1 1 2 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to 24a. Was an autopsy performad? Completed peed completion of cause of death? 785 paga 2 1 Yes 2 HO 1 ☐ Yes 2 ☐ No cartificata Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ZA/Outpatient 3 ☐ DOA this Aftar this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 5 Pending investigation 1 Desture daath. 1 Tyes 2 No n 24 hours after death.

Funeral Director: A lataly filled in by the fu 2 Accident 6 Could not be determined 3 Sulcida 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune complataly fi edicai (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartifier 1.4.99 046502000 xuce 30. Name and eddress of person who completed cause of down (Itam 23e) (Type, Print) 403 Marvel Court, Easton, Maryland 21601 R. Bruce Helmly, M.D., 31. Date filed (Month, Day, Year)

JAN - 5 1999 32. Registrar's Signatura State Registrar

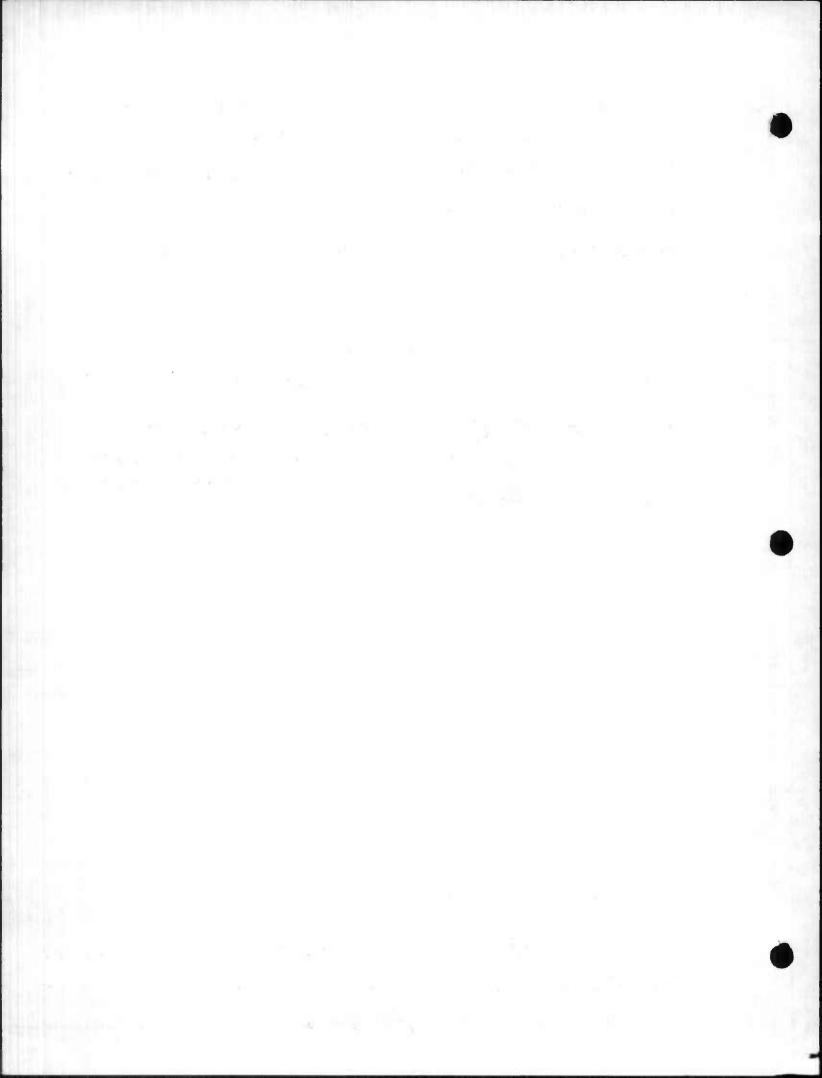
**DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene 99 00879

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1. Decedent's Name (First, Middl	le, Last)					2. Date of D	eath	V	3. Time of Deat
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4a Facility Nama (If not institution		,		4b	. City, Town, or	Location of Dea	th 4c. County		
University of MA	acyland Medical	1 System		8	Altimore	5			
5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birtl	hday) If Unde Months		If Under 24 Hrs. Hours Min.	8. Date of B	rth	9. Birthple	ice (Stete or Form
215-62-0387 Usual Residence of Decedent	1□M 2QF	45 Y	rs. Months	Days	nours Min.	02/15			aware
10a. State 10b. County		10c. City, Town	or Location					10	d. Inside City Lin
MD Car	oline			Fede	ralsbu	rg			1 ☐ Yes 3/☐)
	ine Avenue		10f, Zij		1632		United		
2691 Lorra 1 11. Marital Status 1 Never Married 2 Man 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1  Yes 2 1		13. Wes Dece		panic Origin? (S , Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	o- 14. Rac Blac Specify	e - America ck, Whita, e	
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Elementary/Secondary (0-12)	st grade completed)  College (1-4or 5	5+)	life. DO NOT u	se retired)			State	Fann	Incun
15. Deceder (Specify only higher Elementary/Secondary (0-12)		Ag	ent/Re	cept	ionist		state	rariii	THSU!
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Gerard J. La							eralsbu		
20a. Method of Disposition	a FIG	20b. Place of cemetery	Disposition (Na.	me of other place	,	Date	20c. Location -	City or Tow	m, State
1X→Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Hill	Crest	Ceme	tery 1	/7/99	Federa	1 s b u i	rg, MD
21. Signature of Funeral Service	Licensee		Framp	tom-	Hawkin	s-Esk	w Fune	ral	Home, I
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Part II. Other eignificant conditions  Piffuse Alv	icolar Hemo		the underlying of	cause giver	n in Part I.	1 [ 24a. Wa per	yea 20 No s an autopsy formed?	3 Probe	ra autopsy findin ilable prior to apletion of cause aath?
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/Me Exan	dical	4e. Facility Neme (If not institut	4					b. City, Town, or L		4c. County	999 of Death	8:00	am
Exam	IIIIEI	Fairhaven Ret					S	ykesvill	е	Carro			
Funera Directo	_	5. Sociel Security Number 212–22–6582	6. Sax 1 ☐ M 2 X F	7. Aga (In yrs. les 93	Yrs.	If Under 1 Y Months Da	aar ays	If Undar 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, Apr 30	<sup>Yeer)</sup> 1905	9. Birth Cou Vir	piece (Stete ntp) jinia	or Foreign
r 28a-f show	ctor	Usuel Rasidenca of Dacedant  10e. Stata 10b. Cour  Md Carr	oll	10c. City, Syke	Town or Lo	ecation le						10d. inslda C	City Limits
th with the 23a or 28	Funeral Director	10a. Street and Number 7200 Third Ave	enue			10f. Zip Coo 2178			11	0g. Citizen of USA	Whet Cou	ntry?	
ter dea	þ	11. Marital Status  1 □ Nevar Married 2 □ M  3 ☑ Widowed 4 □ Divorce	Armed F arried 1 ☐ Yas tf Yes. G	2 □XNo ive		Was Decedant If Yas, specify ( 1 ☐ Yas 2 ☐	Cuba	Ispanic Origin? (Sp n, Maxicen, Puarto Specify:	pecity Yas or No- Rican, etc.)	Bla	ce - Amari ck, Whita, y whit		
d 21215-00; filed within 72 hours Hygiene. ther than "natural", out, the Modical En	Completed	(Specify only high Elamantary/Secondary (0-12	lant's Education hest grada complated, Collega	) (1-40r 5+)	(Give	dent's Usual Oc kind of work do DO NOT use re emaker	ona d	during most of work	king	16b. Kind of 8	usinass/in		
ed ala	To Be Co	12 17. Father's Name (First, Midd. George Elliot						18. Mothar's Nem Glenna W		Meidan Sumar	na)		
Maryla d 2 should th and Mer th and Mer traumatic	-	19e. informant's Name/Relation			19b. Malli	ng Addrass (St	treet s	and Number or Ru	ral Routa Number	, City or Town	, Stata, Zij	Code)	
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Baltimor permit. Peges Depertment of I Important: If the any Injury or or		4 ☐ Donetion * 5 ☐ Othar  21. Signature of Funaral Sarvio		Carro		rematic			1/4/99 H	_			7
and and and and and and and and and and	SUCE	Brian	L. Ha	ist.	P.	O. Box	19	ss of Facility Ha 5 Sykesv	ille, Md	erai n 21784	ome 8	Chape	\$I
Physicia		23a. Part1. Entar tha diseese, shock, or haart failura. L	or complications that ist only one cause on	chused the death.	Do not ani	ar tha moda of	dyin	g, such as cerdiac	or raspiratory arre	est,		Approxime interval Be Onset and	rtween
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OX 6 certific nding p	in/Medic	rasulting in daeth) Lest	d	Dua to (or a	s a consec	uenca of):					1		
O. By the ette	rsicia	Part ii. Other significant condi	itions contributing to d	death but not rasulti	ng in tha u	ndarlyling cause	e giva	an in Pert i.	23b. Dld to	bacco use co	entribute t	o the cause	of death?
D bet the deby detac	y Phy	Chronic of	struction	e pulo	nonar	y dis	(80	se_	1 🗆 Ye	es 2□No	377.00	bably 4	] Unknow
corc requirements	Completed by Physician/Me	Diabetes	mellitu						24a. Was a perform	n autopsy ned?	6/	fara autopsy veilabla prior empletion of death?	to
- F # 8	Com								1□ Ya	is 200Mb	1	☐Yes 2☐	] No
of Vital I Physician: The this certificate ral director, peg	Be	25. Was cesa rafarred to medi examinar?	Hospital:				Othe	ne:	th (Check only on				
- S 00 T	ation: To	1 Yas 2 M6  27. Mannar of Death 1 Natural 5 Pan 2 Accidant Inva	28a. Deta		3/Outpetier 8b. Time o injury	28c.	Injury Work	- Britishy no	ome 5 Resida 28d. Describe ho			(y)	
Division or To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 ☐ Suicida 6 ☐ Coul	ld not be rmlned 28a. Place build	e of injury - At homi ling, etc. (Specify)	a, farm, str	eat, factory, off	fice		28f. Location (St. City or Town		ber or Run	al Route Nun	n <i>ber</i> ,
the Hospil in 24 hour the Funera	edical	(Check only 2 Medic	Α	a best of my knowle basis of axamination oner stated.	edge, deeth n end/or in	vestigetion, in r	my or	olnion, daeth occur	red et the tima, de	ete and piece,	and due t	o the ceuse(	s)
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S Regis	tate trar	31. Data filed (Month, Dey, Yes	4 1999	Registrar's Signatur	5	· Los	24.1	41					



,					Sta	ate c	f Man	ylan	J / Department of Health and Mental Certificate of Death	Hygiene 9 9	0088	1
ITEMS:	#23 P	PART	Ι,	27,	28A-F	PER	MEO G	767	Certificate of Death	Reg. No.		

Physician
/Medical
Examiner

1. Decedent's Neme (First, Middle, Last) LINDA CECELIA MILLER 2. Dete of Deeth

3. Time of Death 12:05 PM.

Director

Funeral

à

Completed

8

0

4a Facility Name (If not institution, give street and number)

4b. City, Town, or Location of Death

JANUARY 07, 1999 4c. County of Death

6429 PENNSYLVANIA AVE. APT. #203 5. Social Security Number 579-68-3435 6. Sar 7. Age (In yrs. last birthday) Sex X 1□M 2X F

FORESTVILLE If Under 1 Year If Under 24 Hrs.

PRINCE GEORGES

**Funeral** Director

than "natural", or hams 23e or 28e-f show the Medical Examiner must be notified at

altimore, Maryland 21215-0020

filled within Hygiene.

permit. Pages 1 and 2 should be till.
Department of Health and Mental Hy
Important: if them 27 is mentaed oth
any Injury or other trearmetic event

**Physician** 

/Medical

Examiner

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94

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After

Director:

To the Hospital o within 24 hours at To the Funerel D

Physician/Medical

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Completed

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Certification: To

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tha death certificeta be executed

Box 68760,

P.O.

Records.

Division of Vital or Attending Physician: after death. Usuel Residence of Decedent 10b. County 10a State

10c. City, Town or Location

Yrs.

8. Date of Birth MAY 1234, 17932

9. Birthplace (State or Foreign WASHINGTON DC

MD

PRINCE GEORGES

FORESTVILLE

Hours

10d. Inside City Limits

Yes 2 No

10e. Street and Number

6429 PENNSYLVANIA AVE APT 203 10f. Zin Code 20747

Deys

10g. Citizen of What Country? UNITED STATES

1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates:

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Race - American Indian, Bleck, White, etc. BLACK

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER

16b. Kind of Business/Industry

PRIVATE

Elementary/Secondary (0-12)

46

18. Mother's Name (First, Middle, Maiden Sumeme)

17. Father's Name (First, Middle, Last) PAUL A. SIMMS SR.

MAURINE E. BELL

19a. Informant's Neme/Retetionship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1713 GETHSEMANE WAY, CAPITOL HEIGHTS, MD20743

20a. Method of Disposition

1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)

TINA SIMMS-MARSHALL/DAUGHTER

20b. Plece of Disposition (Neme of cometery, cremetory or other piece)
FORT LINCOLN CEMETERY

20c. Location - City or Town, Stete 1-13-99 BRENTWOOD, MD

21. Signeture of Funerel Service Licensee

22. Name end Address of FacilAN\_EXANDER S.POPE FUNERAL HOME 5538 MARLBORO PIKE FORESTVILLE, MD 20747

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line.

tmmediete Cause (Finel disease or condition resulting in death)

ACUTE OLANZEPINE INTOXICATION

Due to (or es e consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or es a consequence ot):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Ohknown

24a. Wes en eutopsy performed?

24b. Were autopsy tindings available prior to

Approximete Intervat Between Onset and Death

12 Yes 2 No

26. Piace of Deeth (Check only one)

completion of cause of death? 1,244es 2 □ No

25. Was case reterred to medical examiner?

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Found: 1-7-99 5 Pending

investigation

6 Could not be

28b. Time of Fourid: 12:05

Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred SUBJECT INGESTED DRUGS

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State) 6429 PENNSYLVANIA AVE. FOREST VILLE MARYLAND

29e. Certifier (Check only one)

27. Manner of Death

1 Netural

3 X Suicide

2 Accident

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

\*\*Commonship Commonship 9c. License number

29b. Signeture and title of certifier

hugs

O.C.M.E.

29d. Dete signed (Month, Day, Year) JANUARY 08, 1999

30. Name and address of parson who comple fed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 hute 2. Registrar's Signature

Registrar

P

DHMH 16 Rev 6/95



altimore, Maryland 21215-0020

Box 68760.

P.0.

Records,

of Vital

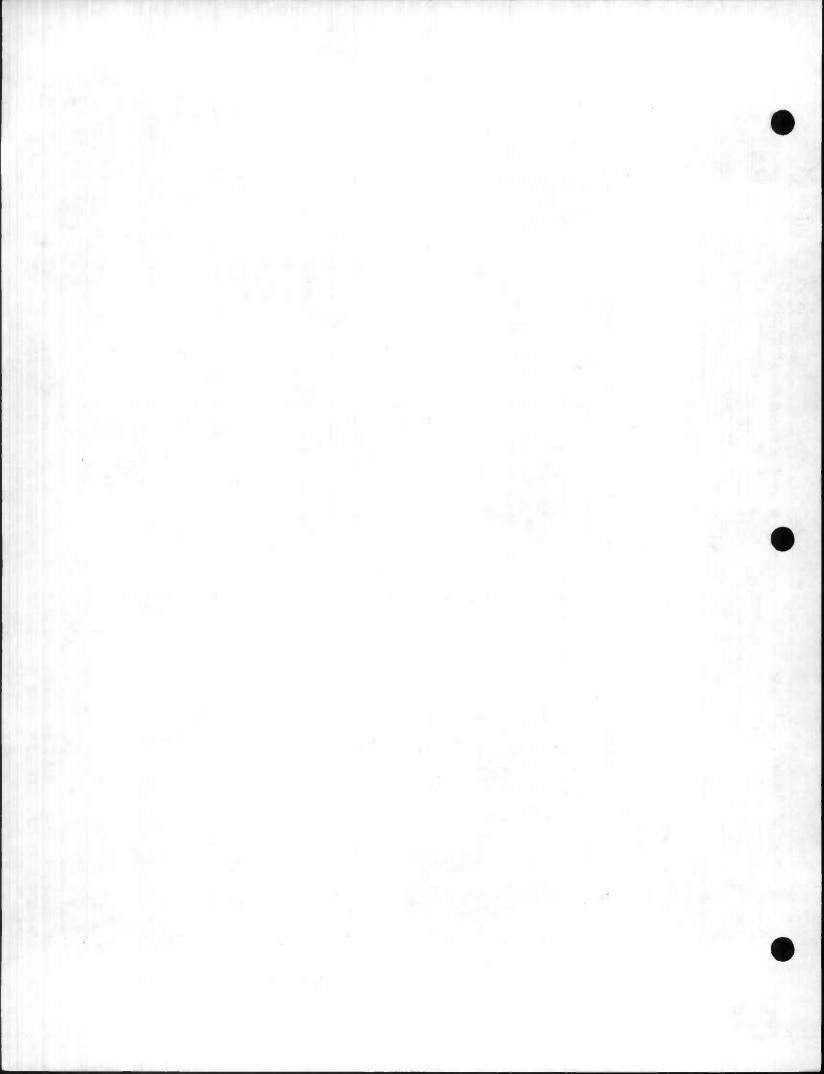
Division

Please Type	or Print in	Black Indelib	le Ink. Ass	sure All C	opies Are	Legible
01-1		1/5		1.5.4		00

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** 10:06 PM anuary RICHARD LEE NETZ /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL WASHINGTON If Under 1 Year 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F 67 Yrs Director 220-28-3079 09/03/1931 MARYLAND Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yes 2 No Directo MARYLAND WASHINGTON **BOONSBORO** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21713 U.S.A. 11 YOUNG AVENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☒ Married Specify: WHITE 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6 YEARS LABORER STATE HWY ADMINISTRATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if fleen 27 is merited oth any fillury or other traumatic event dicks. Be MYRTLE SMITH HARRY NETZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 YOUNG AVENUE, BOONSBORO, MARYLAND 21713 PHYLLIS J. NETZ, WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BOONSBORO CEMETERY 01/06/1999 BOONSBORO, MARYLAND 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility SA. 7606 OLD NATIONAL PIKE STEVEN DANFELT, BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical Examiner Examine The lew requires that the death certificate be executed **buriel-transit** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physicien the burie Physiclan/Medical Due to (or as a consequence of): USB 23b. Did tobacco uss contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed **Dege 2** 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? funeral director. Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Napatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation or Attending 24 hours after death. Funeral Director: A 1 Yes 2 No thei 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edicai 29a. Certifier within 24 hor To the Fune completely fi (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier Jan 2, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOONSBORD MD. 21713 LAPPANS MALIK MD 20311 31. Dete filed (Month, Day, 32. Registrar's Signature

Registrar **DHMH 16 Rev 6/95** 

State



State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death

**Physician** /Medical Examiner

Director

Funeral

P

Completed

Be

**Funeral** Director

the Maryland r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at filed within 72 hours after I Hygiene. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other only Injury or other treumatic event page.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Examiner physician and the burial-transit Physician/Medical signed by the Completed by 8 Certification: To 24 hours after death.

Funeral Director: A

2. Dete of Death
January 1. Decedent's Name (First, Middle, Last) 3. Time of Death 16.02 Teresa Margaret Ottinger 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Washington County Hospital Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Deys Hours 095-12-4139 1 □ M 2 🖾 F 79 Yrs. Jan.7, New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Hagerstown 1 ☐ Yes 2 ☒ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19601 Granada Lane 21742 USA Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Rece - American Indien, Bleck, White, etc. 1 Never Merried 2 X Married 1 ☐ Yea 2 🖄 No If Yes, Give Year or Detea: 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 0 Homemaker Private Residence 17. Fether's Name (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Sumeme) Margaret (Unknown) Patrick Horan 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren E. Ottinger/Husband 19601 Granada Lane, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of commetery, cremetory or other place)

Rest Haven Cemetery—Jan. 8, 1999

Hagerstown, Maryland 20e. Method of Disposition N Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility
Douglas A. Fiery Funeral Home
1331 Eastern Blvd., N., Hagerstown, Maryland 21742 23a. Fart. Enter the disease, of complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, mock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in deeth) RESPIRATORY WEEKS ENCEPHALO PATHY WEEKS 1SCHAEMIC Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of) INFARETION WEEKS MYOCARDIAL Due to (or es a consequenca of): RENAL MSEASE STAGE

YEAR-S Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i, 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Wera autopsy tindings evailable prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospifal: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2NNo 27. Menner of Deeth 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 Tyes 2 □ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, streef, fectory, office building, etc. (Specify) 4 Homicide

29e. Certifier

(Check only one)

154 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and piace, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) and menner steted.

29b. Signature and fitle of certifier

gredfage.

29c. License number

29d. Date signed (Month, Day, Year)

Hagerstown Maryland

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 12931

MONZUF 31. Date filed (Month, Dey, Year)

32. Registrer's Signeture

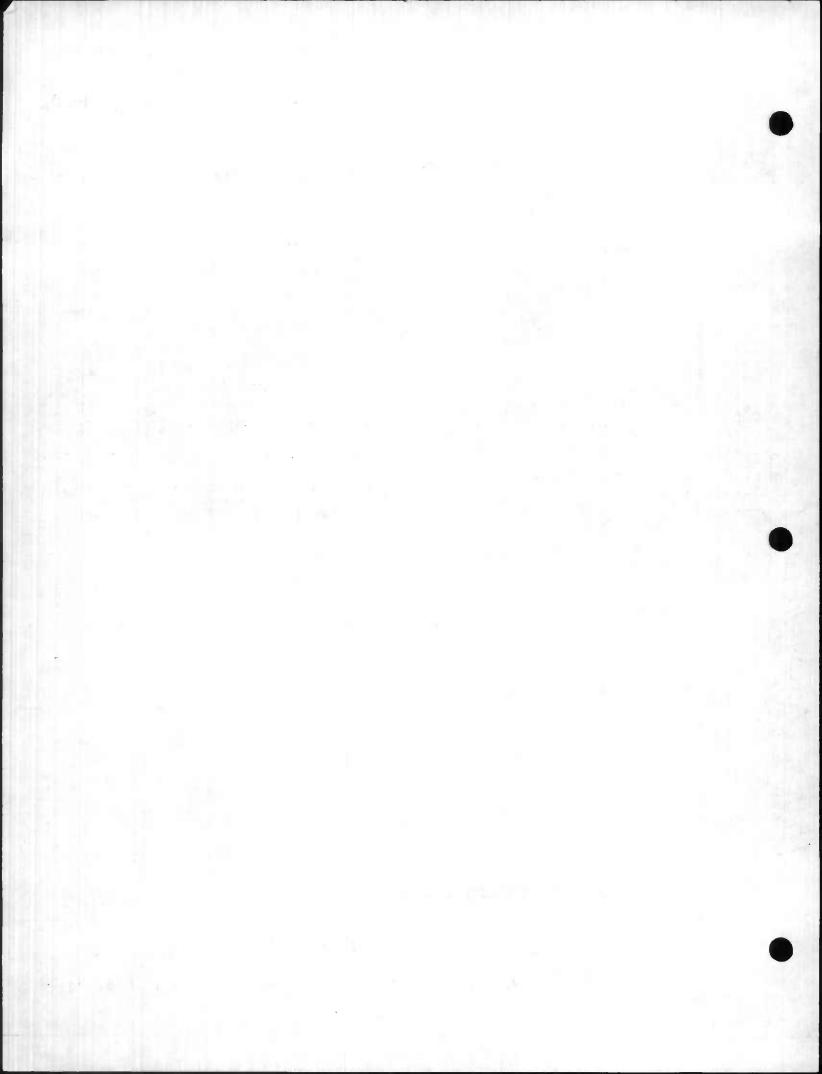
State Registrar

edical

To the Hosp within 24 ho To the Fune completely fi

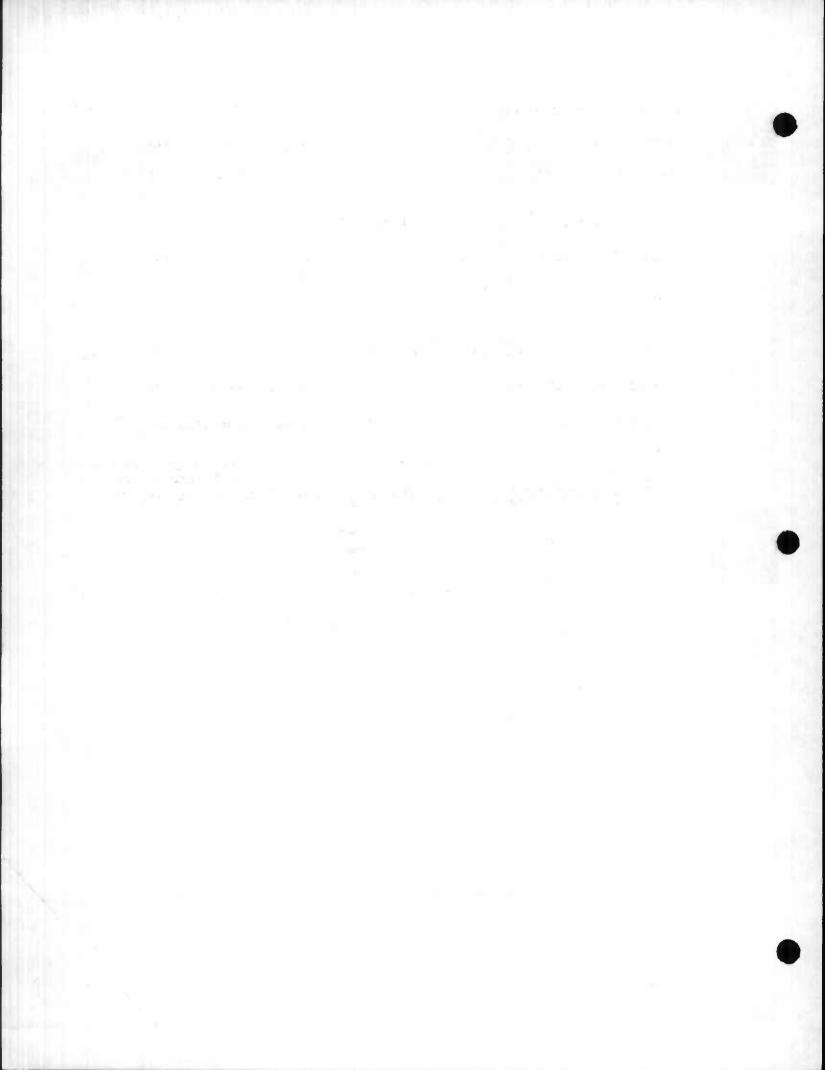
Attending Physicien:

Division



State of Maryland / Department of Health and Mental Hygiene

el Residence of Decedent Stete 10b. County aryland Washin Street end Number 4036 Village Mi Marital Status   Navar Married 2 Married   Secondary (0-12) Widowad 4 Divorced   Specify only highest greenentery/Secondary (0-12) Winknown   Sether's Neme (First, Middle, Last) Ohn Michael 0'C   Informent's Neme/Reletionship on Wright Nie Method of Disposition   Xurial 2 Cremetion 3     Donetion 5 Other (Special Signature of Funeral Service Lice)   Pentl. Entar the disease, or cor shock, or heart feilure. List onititing in deeth)	O CONNOR  ive street and number)  Sing Home  Sex 7. Age (1)  gton 1  12. Wes Decedent Event Armed Foreas? 1   Yas 2   No If Yas, Give Year or Detes:  Education rada completed)  College (1-4or 5+) Unknown  st)  Onnor  (Type, Print)  Ce    Removel from Steta   in the course of the course on each line.	10c. City, Town  Ma  501 er in U,S.  16a.  F  19b. 2  20b. Piece of cemeter,  Rose	In or Location  augansvil  101. Zip of  113. Wes Decede If Yes, specifit Yes, specifit Yes, specifit Yes, specifit Yes, specifit Yes, of the Chie  Mailing Address (Cital San Disposition (Nemey, cremetary or oth Hill Ceme  20 Neme and 415 E.	Hage Year If Under 2 Days Hours  1e Code 21767 If of Hispenic Original Code 21767 If of Hispenic Original Code Code 18. Mother Lilli Street and Number Mar Road of er place) Stery Addrass of Facility	min. (Month, Dan  "No (Specify Yas or N Puerto Rican, etc.)  of working  s Neme (First, Middle an Rebecc or Rurel Route Num  Boonsbo Date  1/6/99 Minnich	Day 3 1999 th 4c. County Wash rth ey, Year) 10 1904  10g. Citizen of V  U.S.  O- 14. Rac Bied Specify  16b. Kind of Bi  Aircr e, Meiden Surner a Miller Der, City or Town, ro, Md. 20c. Location  Hagerste Funeral	r of Death  1 ington 9. Birthpleca (State or Foreignentry) Maryland  10d. Inside City Limit 1□ Yes 2∑N  What Country?  A. De - American Indien, ck, White, etc.  White usiness/industry  State, Zip Code) 21713 City or Town, Siele  Own, Maryland
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II. Other significant conditions			tha undarlying cau	use given In Pert I.			ntribute to the cause of death
							24b. Were eutopsy findings available prior to completion of cause of death?
					1 🗆	Yes 24No	1 ☐ Yes 2 ☐ No
Wes case referred to medical				26. Piece o	of Deeth (Check only	one)	1
Yes 20-No	Hospitel: 1 ☐ Inpatient	2□ ER/Out	tpetient 3 DOA	Other			er (Specify)
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Homicide determined		(Specify)	пп, эпеец, гастогу,	UIIICIB	City or To	own, Stete)	or nurar noute Number,
(Check only 2 Medical Exa	hysician: To the best of n	ceminetion end	deeth occurred ef for investigation, in	the fima, data and my opinion, death	place, end due to the occurred at the time	ceuse(s) end me , dete end pleca,	end due to the ceuse(s)
unej	end menner stated	0.		License number		29d. Dete signe	d (Month, Day, Year)
Signeture end fitte of certifier	end menner stated	<u> </u>	29c.				
N/ 	fes case referred to medical caminer?  Yes 2 N6 anner of Deeth Praturel   Pending   Invastigati     Suicide   Gould nof determine	Tes case referred to medical caminer?  Yes 20100 Hospitel: 1 Inpatient 28e. Dete of Injury (Month, Day') Accident Invastigation Suicide Gould not be determined 28e. Pleca of Injury building, etc. (Certifler Check only 2 Medical Examiner: On the basis of examiner: On the basis of examiner:	Ferrifler (Check only one)  Ferrifler (Check only one)  Ferrifler (check only one)	Fes case referred to medical (aminer?    Yes 20 N6	Certifier (Check only one)   Certifier (Check only one)   Certifier (Check only one)   Certifier (che	Certifier (Check only one)   Check only one)   Certifier (Check only one)   Certifier (Check only one)   Certifier one)   Certifier (Check only one)   Certifier one)   Certif	1   Yes 2   No

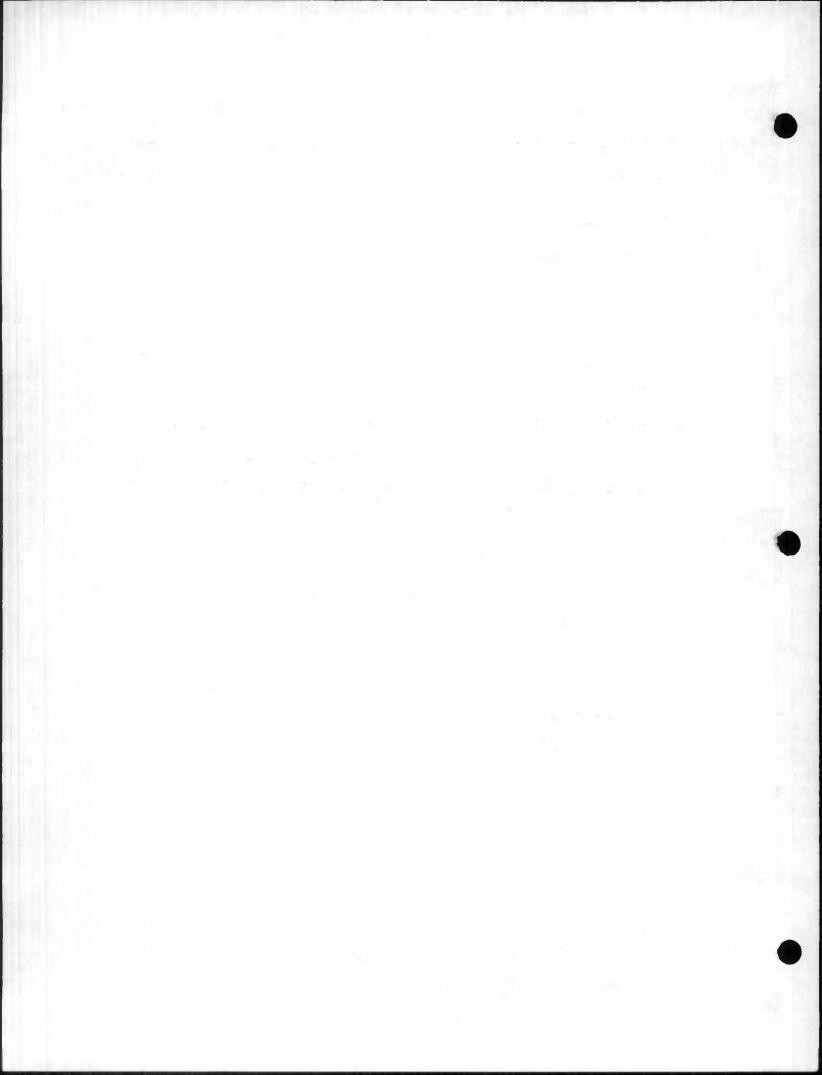


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth **Physician** Month JAN. 1999 Connie Sue Porter 11:54 AM /Medicai 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Columbia

If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)

Min. (Month, Dey, Year) 6506 Beechwood Drive Howard 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 6. Sex Birthplece (State or Foreign Country) **Funeral** Deys 1 M 2Q,F Yrs. Director 219-29-6871 SEPT 27, 1990 Maryland Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumetic event, the Medical Examiner must be notified at 1 Yes 2 No Director Howard Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 items 23a 6506 Beechwood Drive by Funeral 21045 USA filed withIn 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 21215-0020 6 1 Yes 2 No Specify: white Specify: 3 Widowed 4 Divorced "natural', Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. merked other than Elementery/Secondary (0-12) College (1-4or 5+) 0 Child 0 Child Baltimore, Maryland permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is merked other any Injury or other traumatic event. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surname) Be Unknown Judy Porter 0 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Porter - mother 604 Hayes Avenue, Hagerstown, Md. 21740 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State Camp Hill Cemetery 01-08-99 Paw Paw, West Virginia 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service License Andrew K. Coffman Funeral Home, Inc. K. holls 40 East Antietam Street, Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Onset and Deeth **Physician** Immediete Ceuse (Finel diseese or condition resulting In death) /Medicai Examiner The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. ettending physicien Physician/Medical Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detect 1 Yes 2 No 3 Probably 4 Unknown Recurrent preumonia Division of Vital Records, þ 24b. Were eutopsy findings aveilebie prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? General instability due to brainish involvement Seizure disorder 1 ☐ Yes 2 ☑ No this certificate 25. Was case referred to medical exeminer? severe chcep halopalh Attending Physician: 26. Plece of Deeth (Check only one) Be Certification: To Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Inpatient 2 R/Outpatient 3 DOA funeral 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? After 1 PNeturel 5 Pending Investigation ours effer death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours of To the Funeral D completely filled i 15 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature end title of certifier 29d. Dete signed (Month, Dev. Year) 30. Name end eddress of person who completed pause of death (Item 23e) (Type, Print) James Anthony, MD, 8821 Columbia 100 Parkway, Columbia, Md. 21045 31. Dete filed (Month, Day, Year) 32. Hegistrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4×Am Ora Mary PRICE /Medical 4b. City, Town, or Location of Death 4a. Fecility Neme (If not institution, giva straat and numbar) 4c. County of Death **Examiner** Hagerstown Washington Western Maryland Hospital Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours Min 80 Yrs. Director Jan 11 1918 Maryland 213-72-8232 the Maryland 10a. State "natural", or items 23a or 28a-f show ad cal Examiner must be notified at 10h County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen oi What Country? with U.S.A. 21740 902 Pope Avenue Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 월 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 end 2 should be filed within 72 hours after one of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or item into other traumals event, its Medical Examinar my or other traumals event, its Medical Examinar. 1 ☐ Never Married 2 ☐ Merried 21215-0020 1 ☐ Yes 2 No Specify: Specify. Completed by 3 AWidowed 4 □ Divorced White 16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grada complated) Elementery/Secondary (0-12) College (1-4or 5+) 6 Her own home Homemaker Baltimore, Maryland 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Surnama) Be Charles Henry Warne Matilda A. McKencie 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Betty L. Whittington - Daughter 902 Pope Avenue Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removel from Stete permit. Page Depertment of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Spacify) 1/7/99 Rest Haven Cemetery Hagerstown, Maryland 32. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licenses 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Kulmonary Desease Physician/Medical Examiner and I-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last physician ar Box 68760. 0 Due to (or as a consequence of) USB Po P.O. ed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? signed by t 1 1 100 2 No 3 Probably 4 Unknown pe deema Records, Completed by The law requires 24b. Were eutopsy lindings evallable prior to completion of ceuse of death? 24a. Was an autopsy performed? page 2 s has 2 1 No 1 Yes 1 ☐ Yea 2 ☐ No Division of Vital or Attending Physician: diractor, 25. Was case referred to medical examiner? Be 26. Place of Death (Chack only one) Hospital: 1 Ø Impatient 2 ☐ ER/Outpatient 1□ Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Beeth 28c. Injury at Work? 28d. Describe how Injury occurred Certification: Aftar 1 DNaturel 5 Pending Investigation n 24 hours after death.

Ne Funeral Director: After pletaly filled in by the fur 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide edical 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) end menner as stated. npletaly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 To the F 29b. Signature and title of conf field 29c. License number 29d. Date signed (Month, Day, Year) MD 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LETTERSBURG MD SIDDIQUI SHATTA B

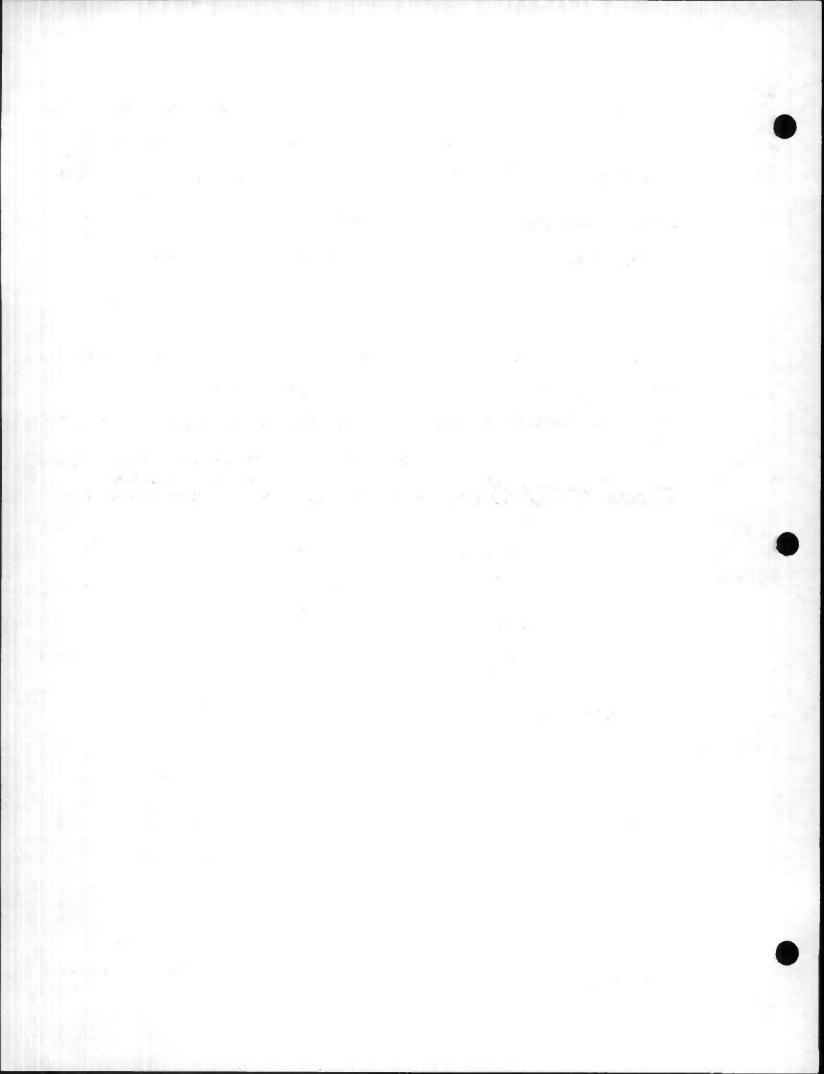
State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 6

32. Registrer's Signature



Please Type of Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month AUDREY EVANS PARSONS 2 99 1 17:55 P.M 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Peninsula Regional Medical Center Salisbury
If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Year) Wicomico 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1□M 2₽F Yrs. 217-03-5530 82 Md. 5/18/16 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. inside City Limits Worcester Ves 2□No Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 307 E. Market 21863 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Rece - American Indian, Bieck, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decadent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Moore Business Elemantary/Secondary (0-12) Coilege (1-4or 5+) Forms Co. press worker, printing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surname) Ida Mae Hales (Evans) Thomas Samuel Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, Steta, Zip Code) 3941 Layfield Rd., Salisbury, Md. 21804 Pat Richardson, (Niece) 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Murial 2 ☐ Cremation 3 ☐ Remove from State Donation 5 Other (Specify) Bates Methodist Cem. 1/5/99 Snow Hill, Md. 21. Signeture of Funeral Servica Licensee 22. Neme and Address of Facility P.O. Box 87 Dennis Funeral Home, Snow Hill, Md. 21863 ·Llennes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediata Cause (Final diseese or condition rasulting in death) Cardiomyopath 10 yrs Due to (or as a consequence of): arten Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated evants resulting in death) Lest Due to (or as/a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy 1 ☐ Yes 🙎 ☐ No 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only ona) Hospital:

29d. Dete signed (Month, Dey, Year)

428 W. Market St.

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

þ

Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

the Maryland

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Vital

Division of

permit. Pages 1 and 2 should be filed within 72 I Department of Health and Mantal Hygiena. Important: if Nem 27 Is marked other than "netu any Injury or other traumatic event and process."

Examiner -transit The law requires that the death cartificate be executed and physician ar Physician/Medical 83 signed by the a þ Completed page 2 s Hospital or Attending Physician: 24 hours after death. Evenus after death. Funeral Director: After this cartifica stay filled in by the funeral director. p Be P Certification:

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 25. Was case refarred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred DO Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner stated. 29b. Signature and title of certifier

@3e) (Type, Print)

State Registrar

To the Hospital of within 24 hours at To the Funeral D completely filled it

Medical

30. Name end eddrass of person who completed cause of deal

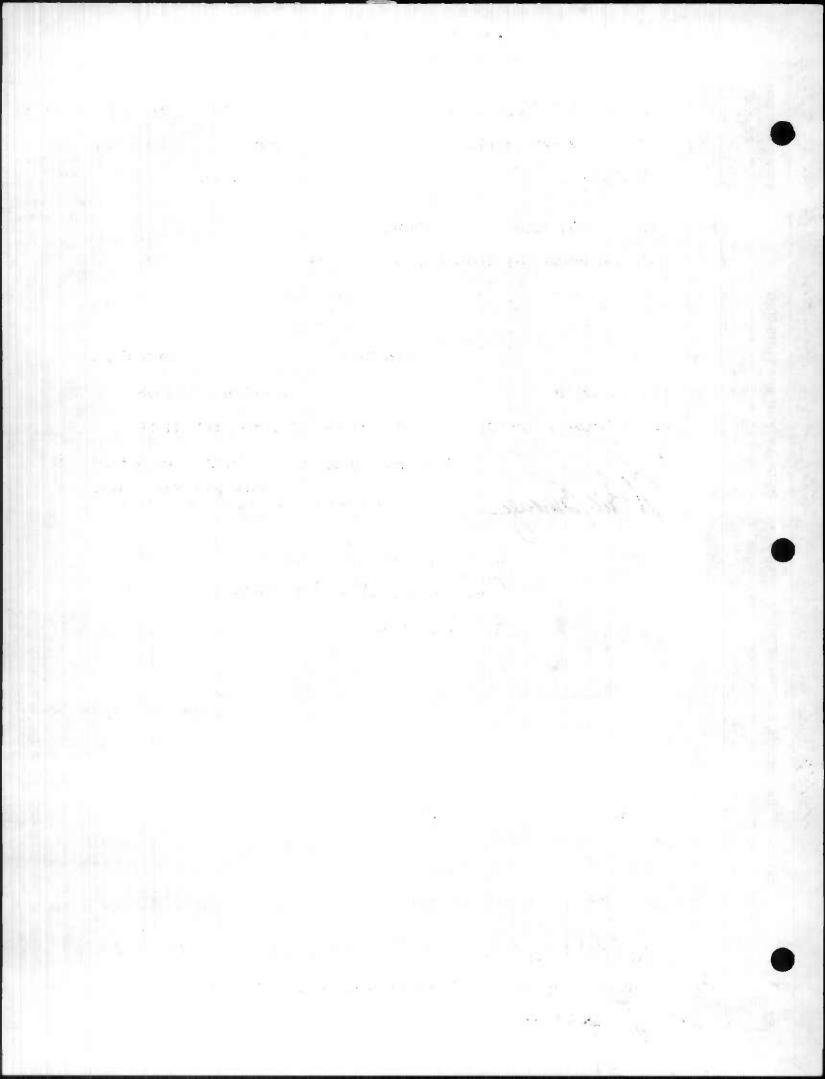
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6 31. Date filed (Month, Dey, Year) Taho.

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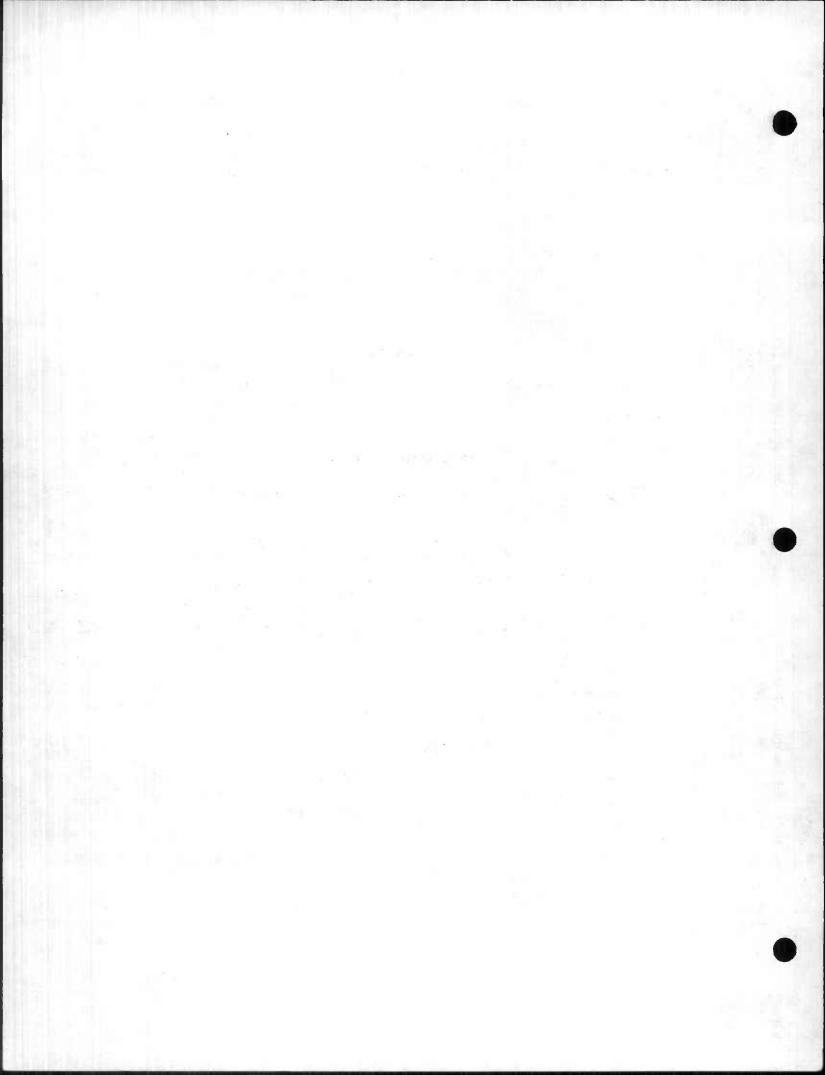
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Quillen Heten 01 12:12 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Atlantic General Hospital Berlin Worcester 0 If Under 1 Year | If Under 24 Hrs. Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) **Funeral** Days 1 M 20 F Yrs. 215-26-5994 67 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow ?? is marked other than "natural", or items 23a or 28a-f ahov traumatic event, tra Moorca Experiment must be notified at 1 XYes 2 □ No Directo MD Worcester Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10218 Old Ocean City Blvd. Unit 803 21811 USA Funeral Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married "natural", or 1 Yes 2 No Specify: Specify. by 3 Widowed 4 X Divorced white 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Seamtress 6 Shirt Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be feel and Mentel John H. Taylor Georgianna E. Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health end Important: If Nem 27 is m Bonnie McCary/ Daughter 10239 Carey RD Berlin, MD 21811 altimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/7/99 Riverside Cemetery Libertytown, MD Service Licensee 22. Name and Address of Facility Burbage Funeral Home Berlin, MD Juhale 108 William St. which disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mean failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examiner ardiovasa ettanding physician end for usa as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) abete P.O. Box 68760. certificate be Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably Unknown signed by of Vital Records, by The law requires 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? certificata has 1 Yes No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Inpatient 2 ☐ ERVOutpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 this funeral 28d. Describe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? After 1 Certification: 5 Pending investigation Division Attending Natural 2 Accident 1 Tyes 2 No death Director 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide aftar ò 24 hours Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical complately (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 99 MUD 30. Name and address of person who com leted cause of death (Item 23a) (Type, Print) Robert Klug, MD 9733 Healthway Dr. Berlin, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAN 0 6 1999 Registrar DHMH 16 Rav 6/95



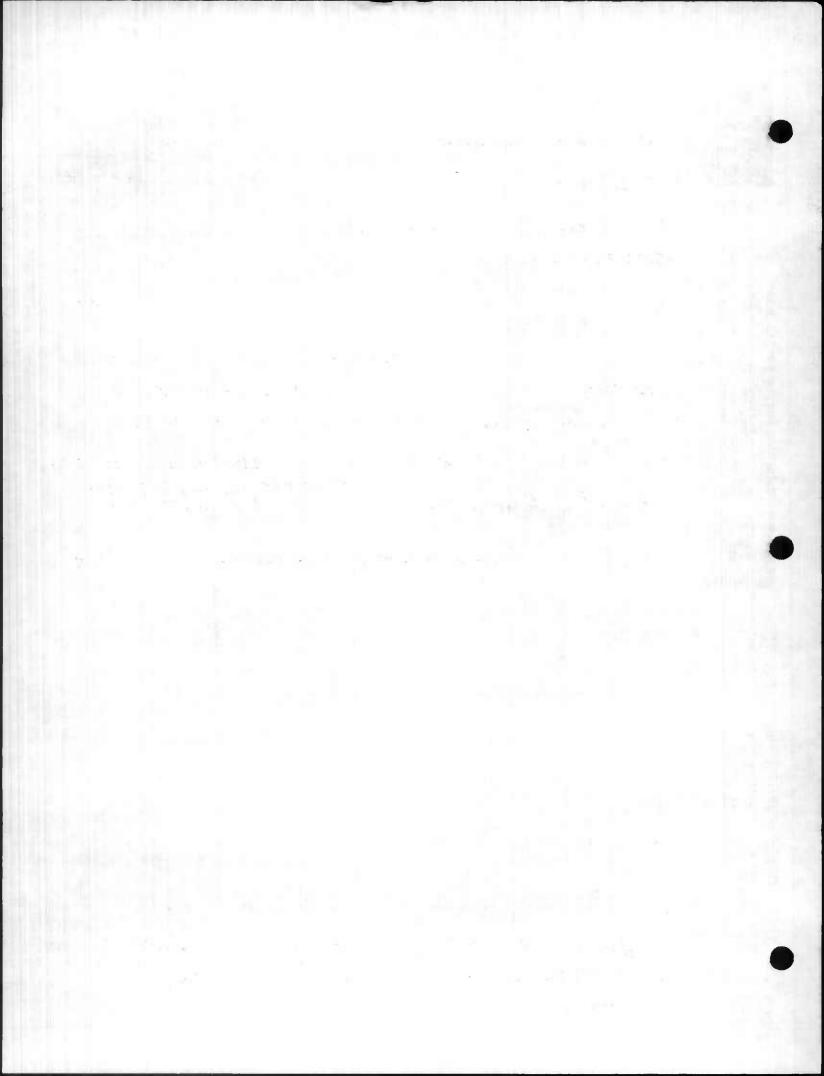
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Physician /Medical	1. Decedent's Name (First, Middle Phyllis Collect								JARY 2,	1999	3. Time of Death 5:30 PM
Examiner	4a Fecility Neme (tf not institution RAVENWOOD	LUTHERAN	VILLAGI	Ξ			own, or L GERS	COWN		nty of Death	GTON
Funeral Director	5. Social Security Number 214-36-0737	6. Sex 1 □ M 25 □ F	7. Age (In yrs. I	last birthday) Yrs.	ff Under 1 Year Months Deys		24 Hrs. Min.	8. Date of E (Month, I	Day, Year)		place (State or Foreign ntry) ryland
D .	Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation					Τ.	IOd. Inside City Limits
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1 2 5 D	11. Merital Status  1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Fo	2⊠No ve		Vas Decedent of I Yes, specify Cul			ecify Yes or t Rican, etc.)	No- 14. Ri Bi	ace - Americ leck, White, hity:	
Maryland 21215-0020 at a should be filled within 72 hours after th and Mental Hygiana. 7 is marked other than "natural; or he traumatic avant, the Medical Examina To Be Completed by Fu	15. Deceden (Specify only higher Elementery/Secondary (0-12) 1.2	t's Education st grade completed)  College (1	1-4or 5+)	(Give tife. L	lent's Usuel Occu kind of work done DO NOT use retin	durina mos	st of work	ing	16b. Kind of Meat I		
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re, Mary 1 end 2 aho Health and A em 27 is ma other traume	19a. Informent's Neme/Refetions Karen C. Doub		Niece		g Address (Stree 2 Carrie						
Page mit o	20a. Method of Disposition  1 X Buriaf 2 Cremetion  4 Donation 5 Other (S)		State	emetery, cren	sition (Name of netory or other pla Cemetery	-	1+.	Dete 5-99	20c. Location		own, Stete Maryland
Baltim pemir. Pa Depertment important: any injury once.	21. Signeture of Funeral Service	Licensee			Neme and Addr		,		h Funera stown, M		nd 21740
death certificate be associated with the conficuration and set of for use as the buriel-transit and for use as the buriel-transit as follow Medical Examiner	shock, or heert feilure. List timmediete Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	e	Due to for	res a consequence of the consequ	uence of): Hea	rl dio	Tu	ila Desce	hy hee		Interval Between Onset and Death  10 years  10 years  20 years.  5 years.
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DIVISION of the or Attending P as a birector: Attentied in by the funerical certification:	3 Suicide 6 Could I 4 Homicide determ	ned 286. Place	of Injury - At ho ng, etc. (Specify	me, ferm, str	eet, fectory, office				(Street and Nur own, State)	mber or Run	et Route Number,
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To the within To the comp	29b. Signeture and title of certifier		qui i	MD	29c. Licen	4503	3 /		29d. Date sign		Dey, Year)
	30. Name and address of person	who completed caus	of death (Item	23a) (Type,	Print) -C/Z	70 BC	380	RG +	Jan Z HA	g N	1021742
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ROHRER, PHYLLIS



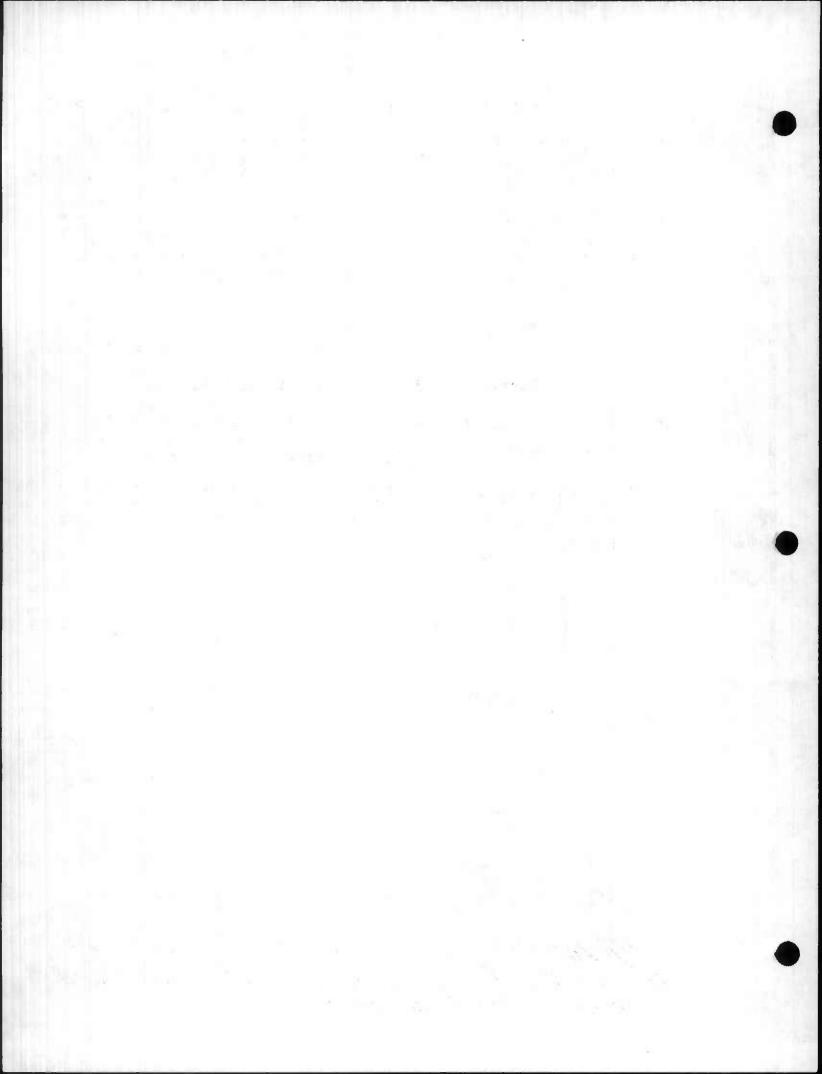
State of Maryland / Department of Health and Mental Hygiene 9 9 0890

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		1. Decedent's Nem	e (First, Middle, Li	ast)		- (TEV)			2. Dete of De		Mais	3. Time of Death
	Physician	MARTHA	RALEY						JANUAR	Y 3,19	99	4:10PM
1	/Medical Examiner	4a Fscility Name (I	If not institution, gi	ve street end nut	m <i>ber)</i>			4b. City, Town	, or Location of Deat	-		
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	Funeral	5. Sociel Security N		Sex	7. Age (In yrs. le	est birthday)	If Undar 1 Yaar	If Under 24	Hrs. 8. Dete of Bir			ace (Stete or Foreign
	Director	218-76-	9621	1□M 22 F	73	Yrs.	Months Days				2111	
		Usual Residence of			/	73 April 7,19						ucky
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Mag	28a-f sho notified at	MD	Charle	C	C	obb T	sland					1 Yas 2 No
di di di	r 28a-f notifie	10e. Street and Nu		5		000 1	10f. Zip Coda			10g. Citizen of	What Count	fry?
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teat	r tems 23a or 28a-f s instrust be notified Funeral Director	11. Marital Status	LOCUMAC	12. Was Dace	danf Evar in U.S	S. 13.	Was Decedent of I	Hispanic Origin	? (Specify Yas or No	USA 14. Red	a - America	
- 4	r kems sherms		ied 2 Married	Armed Fo			If Yes, specify Cub		uarto Rican, etc.)	Ble	ck, White, e	etc.
21215-0020	0 9	3 😾 Widowed	_	If Yes, Giv Year or D	/0		1□ Yes 2 <sup>1</sup> No	Specify:		Specif	Whi	te
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	d other event, I Be Cc	17. Fether's Name	(First, Middle, Las	t)		1100	BLWIIL	18. Mother's	Neme (First, Middle			
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Maryland	and Mental Hygiene. Is marked other than aumatic event, the It	19a. Informent's No	-	(Type, Print)		19b. Meili	ng Address (Street		or Rurel Route Numb		State, Zip	Code)
M	9 5 5	Jeanie :			r				b IslAND			
0 .	item 27 other t	20a. Method of Dis			20b. PI	ece of Dispo	sition (Neme of		Date	20c. Location		wn, State
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Bai	Department of Important: If any Injury or once.	21. Signatura of Fu	inarai Service Lice	nsaa	1	Ä	REHART -	-ECHOL	S FUNERA	L HOME	P.A	
	70260	Ha	vil C.	Echo	1 Moo				LA PLATA			
-		23a. Part1. Enter to shock, or hea	he disease, or con	nplications that c	aused the death	. Do not en	ter the mode of dyi	ing, such as ca	rdiac or respiratory a	rrest,		Approximate Interval Between
P	hysician											Onsat and Death
	/Medical	Immediate Ceuse disease or condition		CHRO	ONTO OF	STRII	CTIVE L	IING DI	SEASE			use
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office	physician and stransit and buriel-transit	Sequentially list co	nditions	b	Due to (or	es e conse	quence of):					
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Bo.	signed by the attending to be detached for use by Physician/N	Det II Other signif	Itaana aandialaan	annielle stiene to ele	anth had not seen	diam in the c	and and an annual of	iven la Pent I	22h Did	tohoooo waa aa	mtelbute to	the causs of death?
0 5	y the iche	Part II. Other signif	icant conditions	contributing to de	eain out not resu	iting in the u	indenying causa gi	ven in Part I.				
م ت	dete det								10	Yes 2 No	3 Proc	bably 4 Unknow
Records,	Sign of P								Ode Wes	an autopsy	24h We	ere autopsy findings
0	been si should								perf	ormed?	ava	allable prior to
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of Vita	90	examiner?	No	Hospital:	npatient 2 0	ER/Outpetie	nt 3 DOA Ot	her: 4 Nursi	ng Home 5 Res	idenca 6 □Otl	ner (Specif)	0
1 Of	er this neral di	27. Menner of Deet		28a. Dete	of Injury th, Dey Year)	28b. Time o	f 28c. Inju	iry at ork?	28d. Describe	how Injury occu	rred	
Division	al Director: After to be the funeral control of the funeral Certification:	1 Natural 2 Accident	5 Pending investigation		in, boy roul,	injury		Yes 2□No				
VIS	octor: A by the fu ificati	3 ☐ Suicide 4 ☐ Homicide	6 Could not ! determined	20e. Piece	of Injury - At ho	me, farm, st	reet, factory, office		28f. Location	Street and Num	ber or Rura	I Route Number,
0 0	din din	4 D Homicide		buildi	ng, etc. (Specify	)			City or To	wn, Stete)		
spice	A fille	29a. Certifier	1 Certifying P	hysician: To the	best of my know	vledge, deet	h occurred et the ti	ime, date and p	place, end due to the	cause(s) end m	enner as st	ated.
H	n 24 hound ne Funer pletely fill edical	(Check only one)	2 Medical Exa	miner: On the ba	asis of examinati ner stated.	ion end/or in	vestigation, in my	opinion, death	occurred et the time	date and pleca,	and due to	the cause(s)
To the Hospital	within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29b. Signatura and	title of certifiar				29c. Lican	sa number		29d. Date signe	ed (Month, I	Day, Year)
	\$ <b>⊢</b> ö	110	200	1	Man		D28	352		JANUAI		116
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		KRISHAN	THIRM TAM	completed caus	P.O.	BOX Type	2729, L	A PLAT	A, MD	20646		
	State	31. Date filed (Mon	AN 07 1	999 32. R	egistrar's Signet	ure 4	Loon					
	Registrar	c	1111 0 1 1	JJJ		Jan.	BOOL	60/				



State of Maryland / Department of Health and Mental Hygiene 9 9

Physic	ion	1. Decedent's Nar	ne (First, Middle, L	ast)			tificate of		2. Date of De	ath Day	Year 3. T	ime of Death
/Medi				GEORGI		RED	INGTON		01	02	99 7	30
Examiı	ner	SADA BECKE AND THE		ive street and numb				4b. City, Town, or I				
300				neral Ho				Cambri	~		nester	
Funeral Director		5. Social Security 215 - 10 -	5326	Sex 7. 1□ M 2X F		est birthday) 4 Yrs.	Months Days		8. Date of Birl (Month, Da 08/22/	h y, Year) 04	9. Birthplace (Country) Maryla	State or Forei
show ad st	J.	Usuel Residence	10b. County	nester	10c. City	, Town or Loc		ambridge	2			side City Limi
28a-	ect	10e. Street and No					10f. Zip Code	ambi rag		10g. Citizen of V		100 201
Pa or	Ö		enburn	Avanua			Tot. Zip Code	21613			-	
22	era	11. Marital Status	enbuin	12. Was Decede	nt Ever in U.	S. 13. W	as Decedent of H		pecify Yes or No		State	
jene. r than "natural", or items 23a or 28a-f show the Moolical Exprimer must be notified at	by Funeral Director		ried 2 Married	Armed Force 1 Yes 2 If Yes, Give Year or Date	XNo		Yes, specify Cub  ☐ Yes 2 No	Hispanic Origin? (Span, Mexican, Puerto Specify:	Ricen, etc.)	Specify Specify	ck, White, etc.	
ical	ted	/Co.	15. Decedent's E	ducetion		16a. Decede	ent's Usuai Occup	pation		16b. Kind of Bu	usinass/Industry	
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ygien t.	Con	6				Se	amstre	SS		Garr	nent Fa	ictory
d oth	Be	17. Father's Name	(First, Middle, Las	•				18. Mother'a Nam			,	
I Health and Mental Hygiene. tem 27 is marked other than other traumatic event, trail	P_C			Martin					oeth S.			
9 50 50			eme/Relationship		on			t and Number or Ru				
Health sm 27 ther tr		Martin 20a. Method of Dis		ington,			ition (Name of	99A, D			19939	
50 1000		1 X Burlei 2		☐Removel from Sta	CE	metery, cremi	w Ceme		Date 1/5/99		City or Town, St	
Dependment of Important: If any injury or once.		21. Signatura of F	uneral Service Lice	Eskur-		F		m-Hawkii				
E 00		23a. Part1. Enter	the diseasa, or con	nplications that caus	ed the death	. Do not enter	r the mode of dyir	43, Fed	or respiretory er	rest,	Appro	oximate al Batween
ysician Medical		Immediete Ceuse disease or conditi	(Finel								Onse	t and Death
aminer		resulting in death)		a	Due to for	as a consequ	ance of):					days
*	ine		_	Sh	OCK						2	drys
end -trans	Examiner	Sequentially list co	onditions,	0.	Due to (or	as a consequ	ence of):	1		·· <u>·····</u> ·		
clan		Sequentially list or if any, leading to in cause. Enter Und Causa (Disaasa of that initiated event	arlying	Ita	ete k	eun	1 frel	ure			2	days
physician end is the burial-transit	edicai	that initiated event resulting in death)	Last		Due to (or	es e consequ	ence of):					
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by the standard	Physician/N			contributing to death		_	terlying ceuse giv	ven in Part I.	23b. Dld 1		ntribute to the c	
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been sign	Completed by	Den	enlis							an autopsy med?	24b. Ware aut eveilable completio	prior to on of cause
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ificate or, pa	m	examiner?		Hospital:	tient 2 T F	R/Outpetient	3 DOA Oth	26. Place of Dea	ome 5 Resid		or (Conside)	
certificate irector, pa	0			28a. Date of Ir	jury	28b. Time of	28c. Injur Wor	-		ow injury occurr		
this certificate al director, pa	2	27. Manner of Deal		(Month, L	Jay Year)	Injury		rk?  Yes 2□No				
After this certificate uneral director, pa	2	1 Natural	5 Pending invastigation	n								
octor: After this certificate by the funeral director, pa	2		5 Pending	28e. Place of I	njury - At hor etc. (Specify)	me, farm, stree	et, factory, office		28f. Location (5 City or Tox	Street and Numbern, State)	er or Rural Route	Number,
<ul> <li>4 nours arier deam.</li> <li>Funeral Director: After this certificate tely filled in by the funeral director, pa</li> </ul>	Certification: To	1 Accident 3 Suicide	5 Pending invastigation 6 Could not be determined	28e. Place of I	etc. (Specify)	riedos, dasth c	occurred at the tin	ma, date and place, pinlon, deeth occur	City or Tow	n, State)	nnar as stated	
<ul> <li>4 nours arier deam.</li> <li>Funeral Director: After this certificate tely filled in by the funeral director, pa</li> </ul>	2	1 Natural 2 Accident 3 Suicide 4 Homicide  29e. Cartifier (Check only	5 Pending invastigation 6 Could not a determined  1 Certifying Pi	28e. Place of I building, on yelclan: To the best miner: On the basis	etc. (Specify)	rledga, daath c on and/or Inve	occurred at tha tin stigation, in my o	opinion, deeth occur se number	City or Tow and dua to tha c red et tha time, c	ause(s) and ma date and place, s	nnar as stated. and due to tha ca	iuse(s)
octor: After this certificate by the funeral director, pa	edical Certification: To	1 Accident 2 Accident 3 Suicide 4 Homicide 29e. Cartifier (Check only one)	5 Pending invastigation 6 Could not a determined  1 Certifying Pi	28e. Place of I building, on yelclan: To the best miner: On the basis	etc. (Specify)	rledga, daath c on and/or Inve	occurred at tha tin stigation, in my o	opinion, deeth occur se number	City or Tow and dua to tha c red et tha time, c	ause(s) and ma date and place, s	nnar as stated. and due to tha ca	iuse(s)
<ul> <li>4 nours arier deam.</li> <li>Funeral Director: After this certificate tely filled in by the funeral director, pa</li> </ul>	Medical Certification: To	1 Accident 2 Accident 3 Suicide 4 Homicide  29e. Cartifier (Check only one)  29b. Signature and	5 Pending invastigation of Could not to determine of Certifying Pt 2 Medical Examination of Certifier	28e. Place of I building, on yelclan: To the best miner: On the basis	etc. (Specify) it of my know of axamination stated.	rledga, daath c on and/or Inve	occurred at tha tin stigation, in my o	ppinion, deeth occur	City or Tow and dua to tha c red et tha time, c	ause(s) and ma date and place, s	nnar as stated. and due to tha ca	iuse(s)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Date of Death Month **Physician** JAN. 04 Evelyn Louise Shannon /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Washington County Hospital Washington Hagerstown Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Min. Hours 1□ M 2☑ F Months 232-58-7431 64 Director Oct. 8. 1934 West Virginia Usual Residence of Decedent the Menyland 10a State 10b. County 10c. City. Town or Location than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Maryland Washington 1 ☐ Yes 2 ☑ No Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13921 Pennsylvania Avenue 21742 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 72 hours after 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: SpecWhite 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry nd Mentel Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 0 Homemaker Private Residence Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi h and Mentel H 7 ie marked ott Be Herbert Lipscomb Florence Helmick Demit. Peges 1 and 2 a Department of Heelih an, important: If item 27 is many injury or other termones. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) John Clardon Shannon/Husband 13921 Pennsylvania Avenue, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlel 2 ☐ Cremation 3 ☐ Removel from State Parsons City Cemetery-Jan. 8, 1999 Parsons, West Virginia 4 Donation 5 Other (Specify) 21. Signature of Furieral Sewige Licen-22. Name end Address of Fecility
Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, 23a. Part1. Approximete interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In deeth) /Medical acute cardiac minuter Examiner Due to (or as a consequence of): Myecardla 15 12 cm Examin buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): physician sthe buriel Physician/Medical Due to (or as e consequence of) Box USe i Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No à 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1□ Yes 2₽No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examinar? Be 26. Place of Deeth (Check only one) To Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 40 1 Inpatient 2 PER/Outpatient 3 DOA this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred edical Certification: Division 1 Netural 5 Pending investigation death. 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, lactory, office building, etc. (Specify) 4 Homlcide 6 To the Hospital within 24 hours a To the Funeral Completely filled 1Startifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D0025714 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 11110 Medical Campus Rd. Hag, Mb 21740 B. Maywood homas 31. Date liled (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Ray 6/95

State

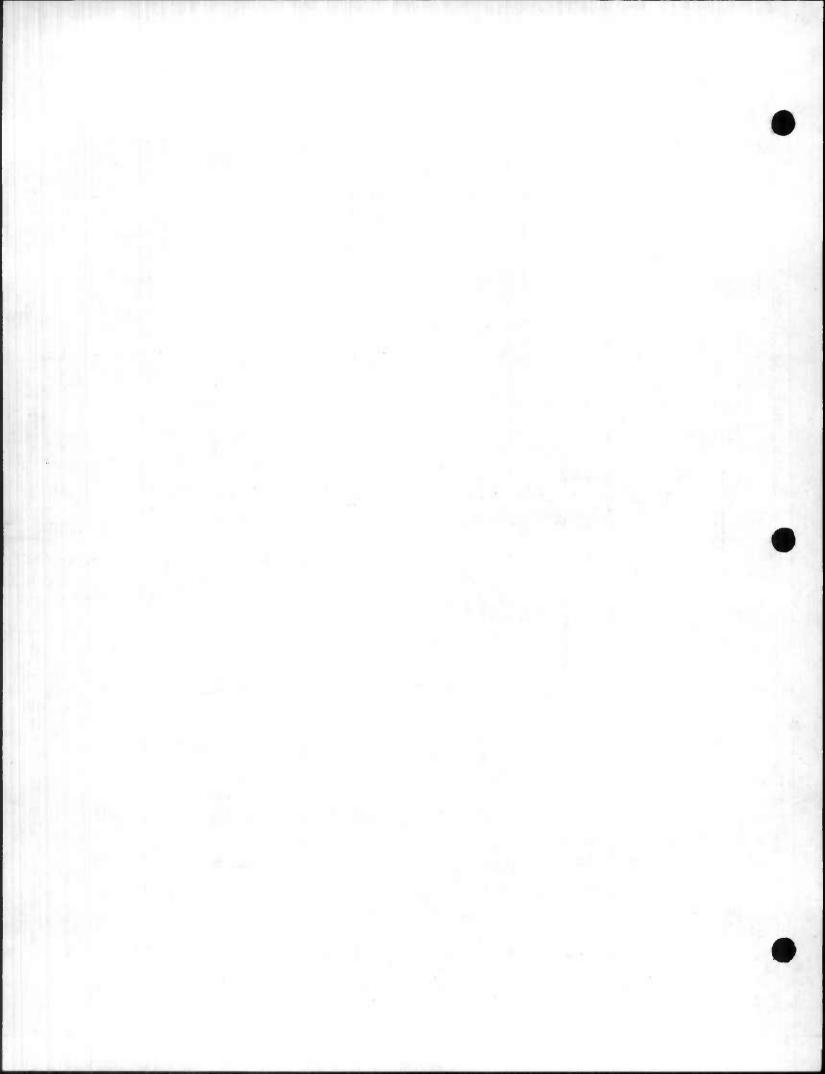
Registrar

JAN 0 5

N M

Evelyn Louise

HAMMON,



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Month 10:45a.

"natural", or harms 23a or must be after filed within 7 Hygiene.

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

physician and s the burial-transit The law requires that the death certificate be executed signed by the at d be detached for or Attending Physician: this after death. To the Hospital or Atta within 24 hours after ded To the Funeral Director completely filled in by th

Division of Vital Records. P.O. Box 68760.

1. Decedent's Name (First, Middle, Last) **Physician** BEVERLY SOVITSKY 1999 JAN 3 /Medical 4s Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Center of Maryland Medical Baltimore Baltimore City University 6. Dete of Birth (Month, Day, Year) Mar 27, 19 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Davs Months 1 M 2 XF 45 212-60-0221 Maryland Director Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show Baltimore 1 ☐ Yes 2 XNo MD Baltimore Director 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 6716 Campfield Road U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black White etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Yes 2 No Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerical Receptionist 18 Mother's Name (First Middle Meiden Sumame) 17. Father's Neme (First, Middle, Last) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental 1 mportant: If Item 27 is marked or Jordan Estella Eleanor Towson Ross 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Mr. Bernard J. Sovitsky (Husband) 38 Chase Avenue, Avenel, NJ 00871 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremation 3 ☐ Removel from State Loudon Park Cemetery 1/6/99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400 RI 23a. Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death fmmediate Cause (Final hemorrhage diseese or condition resulting in deeth) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): edical 1 Due to (or as a consequence of):

Part fl. Other eignificant conditione of	ontributing to death but not res	sulting in the underlying	g cause given in Pert I.	23b. Did tobecco use co	ontribute to the cause of death'  3 Probably 4 Unknow
				24a. Wes en eutopsy performed?	24b. Wera eutopsy findings available prior to completion of cause of death?
25. Was casa referred to medical examiner?			26. Place of D	eath (Check only one)	
1 ☐ Yes No	Hospital:	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)
27. Menner of Death  1 Natural 5 Pending 2 Accident Investigation		28b. Time of fnjury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	Ted
3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	iome, farm, street, fectify)	ory, office	281. Location (Street and Numb City or Town, Stete)	ber or Rurat Route Number,

State Registrar

**DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year) JAN 0 5 1999

29b. Signeture end title of certifier

KATRINA



RESIDENT

Greene 87.

29c. License number

StelaSD

Baltimore

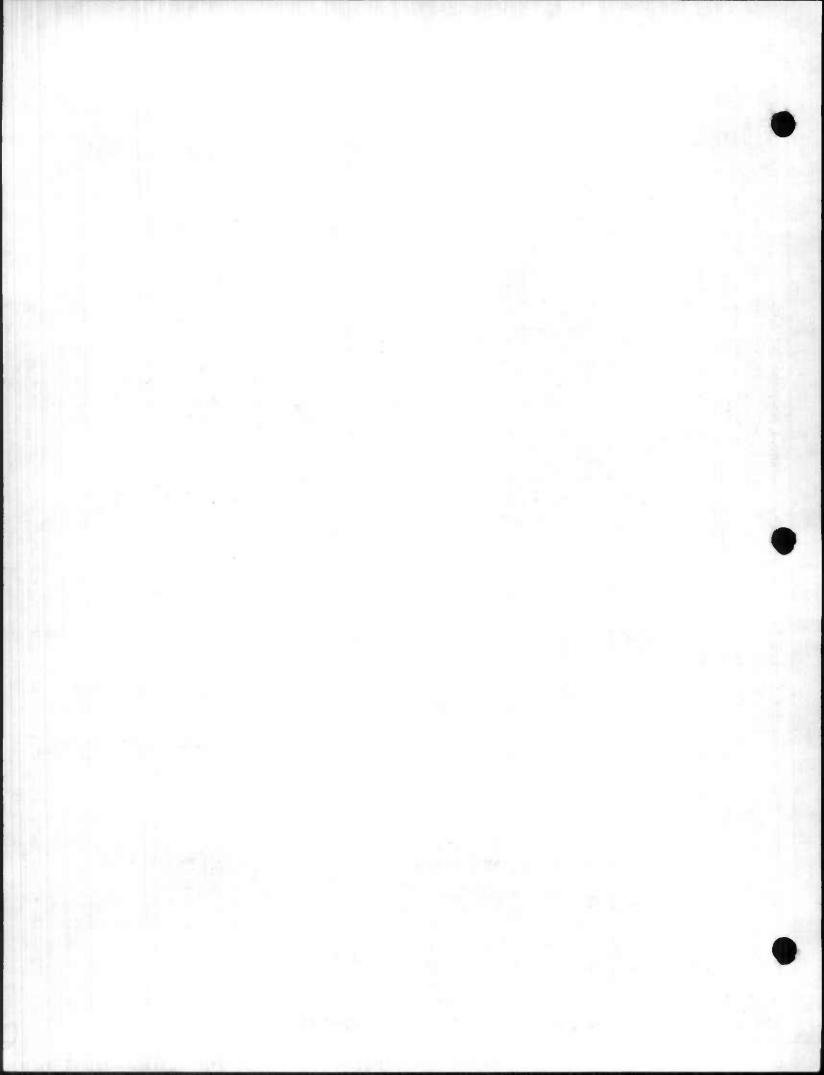
29d. Date signed (Month, Day, Year)

1999

21201

22 S.

30. Name and eddress of person who completed cause of death (ttern 23a) (Type, Print)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last, Date of Death 3. Time of Death :30 AM 1999 4b. City, Town, or Location of Death WESTMINSTER CARROLL If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, If Under 1 Year Months Deys 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) Months Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits STMINISTE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 80 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Maritel Status 14. Race -American Indian. Black, White, etc. Armed Forces 2 Married 1 2 Yes 2 No If Yes, Give 1040 - 46 Year or Dates: 1040 - 46 1 Never Married 1 ☐ Yes 2 ☐ No Specify 4 Divorced 3 Widowed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) BEACON STEEL PRESIDENT 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Eather's Name (First, Middle, Last) MYRTLE Annis is (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAIN STEELT SLEE MA. 21157 19a. Informant's Name/Relationship (Type, Print) 39 20b. Place of Disposition Warney Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from State EVERGREEN MEM. GARBERS 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MAG Substant Bardiac Of respiration 21. Signature of Funeral Service Licen FUNERAL HOME & CHAPEL 412 WAShINGTON Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ 100 1 Yes 2 10 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 N 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Natural

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show

ir than "natural", or Items 23s or 28s-f shorte Medical Examiner must be notified at

Peges 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural; or Ite

other traumatic event,

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permit. Pege Department of Important: If any Injury or once.

altimore, Maryland 21215-0020

Director

Funeral

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ettending physician and for use as the bunal-tran sate hes been signed by the e certificate hes

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral

Examiner Certification:

Physician/Medical

2

þ Completed Be

> 3 Suicide 4 Homicide 29a. Certifier

29b. Signature a

2 Accident

6 Could not be determined

5 Pending investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and (Month, Dey, Year)

30. Name and address of person v ho completed cause of deeth (Item 23a) (Type, Print) 224 Washington Delopho, Westminster, mb 21157 Kruter.

Flavio 31. Date filed (Month, Day, Year)

JAN 0 4 1999

32. Registrar's Signature

State Registrar

completely filled in by

Medical

Acres 1. 199 1. 3021 Little and English R LEAVE IN THE PARTY OF THE PARTY AND CARROLL STRINGS OF Service of the servic Server STEEL HALL A SOUTH A CHILL MANY ACC TOWN AND THE PART OF THE P 115450

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month EUGENE EDWARD SNOW 0854 JAN 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth 743 Dividing Rd. Severna Park Anne Arundel 6. Sex 1Ã M 2 ☐ F If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 19,1921 9. Birthplace (S. Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 77 Yrs 219-01-7852 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2€ No Maryland Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 743 Dividing Rd. 21146 USA 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian, Black, White, etc. I ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1₺ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Civil Service Elementary/Secondary (0-12) College (1-4or 5+) Master woodworker Coast Guard 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Sidney Snow Frances Elizabeth Hebler Snow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Snow/nephew 25672 Bee Tree Rd., Henderson, MD 21640 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/8/1999 Baltimore, MD Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle & Helfenbein Funeral Home Greensboro, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Deeth Immediate Ceuse (Final disease or condition resulting in death) Arterioselerofic Heart Disease Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical

Physician /Medical Examiner

**Physician** 

/Medicai

**Examiner** 

Director

Funeral

by

Completed

10a State

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f ahow treumstic event, its Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23e eny Injury or other treumstic event

Maryland 21215-0020

Baltimore,

with the Maryland

Examiner Physician/Medical Completed by has this certificate Be Certification: To funeral After 24 hours after death. Funeral Director: A the filled in by

The law requires that the death certificate be executed

or Attanding Physician:

Hospital

within 2 To the

Box 68760.

of Vital Records, P.O.

Division

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. ANCINOMA, COLON

26. Piece of Deeth (Check only one)

examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 MResidence 8 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. injury at Work?

1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. 29a. Certifier (Check only one)

29b. Signeture and title of certified Deputy

end address of person who come ed cause of death (Item 23a) (Type, Print)

695 AMEVICA 21035 1/1/m ones, 31. Date filled (Month, Dey, Year)

JAN - 6

State Registrar

Medical

32. Registrer's Signeture 1999

A 1501 By A BASE OSSES OF

State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Physician A Smith, 7:40PM JOHN 1999 Jan /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot The Memorial Hospital Easton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1⊠M 2□ F Months Days Yrs. 219-16-6808 74 July 14 1924 England Director Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show many or other than "natural", and item is not item than a notified any or other traumatic event, in Medical Engine. 1€ Yes 2 No Directo Maryland Caroline Greensboro 10e Street and Number 10f. Zin Code 10g, Citizen of What Country? 415 Academy Street 21639 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Meritel Status Black, White, etc. 1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates: 1943-46 1 Never Merried 2K Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th sheet metal ship fitter Coast Guard 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Alfred J. Smith Alice Newell Smith 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary A. Taylor/ daughter 12738 Knife Box Road Greensboro, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 🖾 Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Cn 1/10 Chester, Maryland 22. Neme end Address of Fecility 21. Signature of Funeral Service Licensee, Fleegle & Helfenbein Funeral Home, PA P.O. Box 160 Greensboro, MD

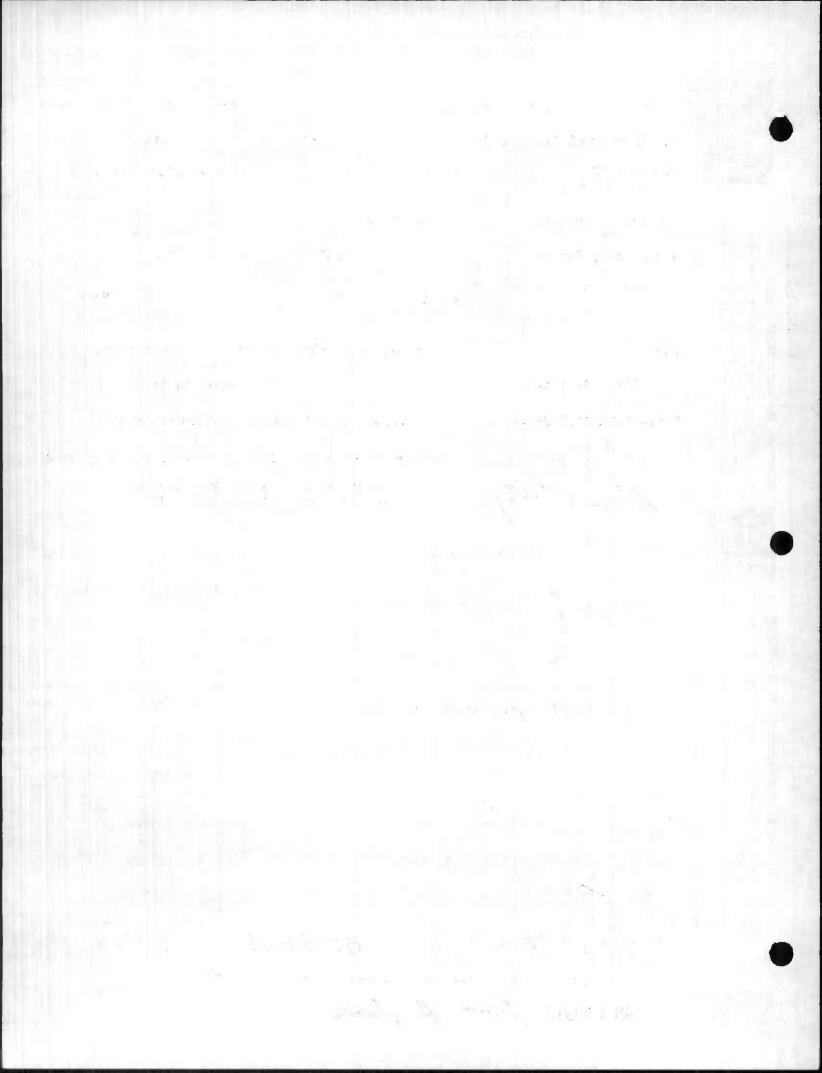
23a. Fartl. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart fellure. List only one cause on each line. P.O. Box 160 Greensboro, MD 21639 Approximete Intervei Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 4 days Examiner Due to (or as e consequence of) Examiner physician and s the bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be execu Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): d for use as t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown meumania signed t þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy Completed certificate has b 1 Yes 2 No 25. Was cese referred to medicei examiner? 12 Yes 2 □ No 27. Mehner of Deeth Hospital or Attending Physicien:
 24 hours after death.
 Funeral Director: After this certificietely filled in by the funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Impetient 2 ER/Outpatient 3 DOA Certification: To 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Neturel 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 99 Many man DO 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 219 S. Washington Street Easton, MD 21601 Nancy F. Snow 31. Date filed (Month, Dey, Year)

Registrar

JAN 1 1 1999



John Smith



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month JAW **Physician** 188 SPEDDEN 10:15a DONALD 1999 3 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Medical Baltimore enter If Under 1 Yeer University of Maryland If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Director 214-12-5835 80 Aug. 2, 1918 Maryland Usual Residence of Decedent the Maryland 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits x 28a-f show 1 ☐ Yes 2 No Directo Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with h and Mental Hygiena. 7 ie marked other than "natural", or Hema 23a or treumetic event, the Medical Examiner must be 6140 Todd's Point Road 21613 U.S.A. death v Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Yeer or Dates: 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hant; if Item 27 is marked oth lury or other treumstic even Be Chaplain Spedden Reita Spedden 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Charlotte F. Spedden/Spouse 6140 Todd's Point Rd., Cambridge, MD 21613 Baltimore, 20b. Placa of Disposition (Name of cemetery, crametory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Buriel 2 □ Cremetion 3 □ Removel from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 1-6-99 Spedden-Seward Cem. Cambridge, MD 22. Name and Address of Facility
Curran-Bromwell Funeral Home, P.A. 21. Signature of Funeral Service Licensee Pent I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feiture. Lief only one cause of each line. 308 High St., Cambridge, MD 21613 Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final intracranial untrown disease or condition resulting in deeth) Examiner Due to (or as a consequenca of): Examiner unknown cerebrovascular physician and the bunal-transit that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physiclan/Medical Due to (or es e consequence of): 50 use 0 signed by the a Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown by 24b. Were autopsy findings evalleble prior to should l Completed 24a. Was an autopsy performed? completion of cause of death? page 2 s 1 Yes 2 No 1 Yes 2 No cartificate Division of Vital Attending Physicien: funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No Inpatient 2 ER/Outpetient 3 DOA After this 28a. Date of Injury (Month, Dey Year) Certification: 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how Injury occurred Natural 2 Accident 5 Pending 1 Yes 2 No death. investigation after death Director: the Funeral Director filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 1999 JAN aluna RESIDENT 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

JAN 1 5 1999

KATRINA MURPHY

32. Registrar's Signature

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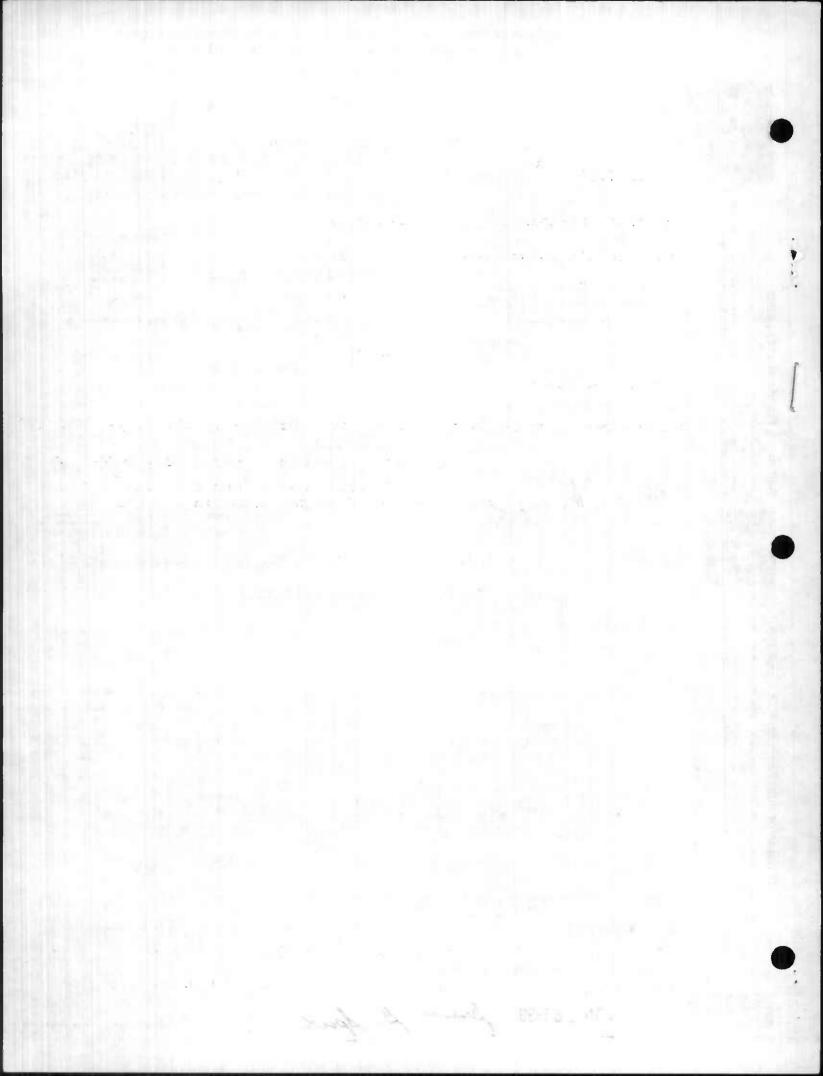
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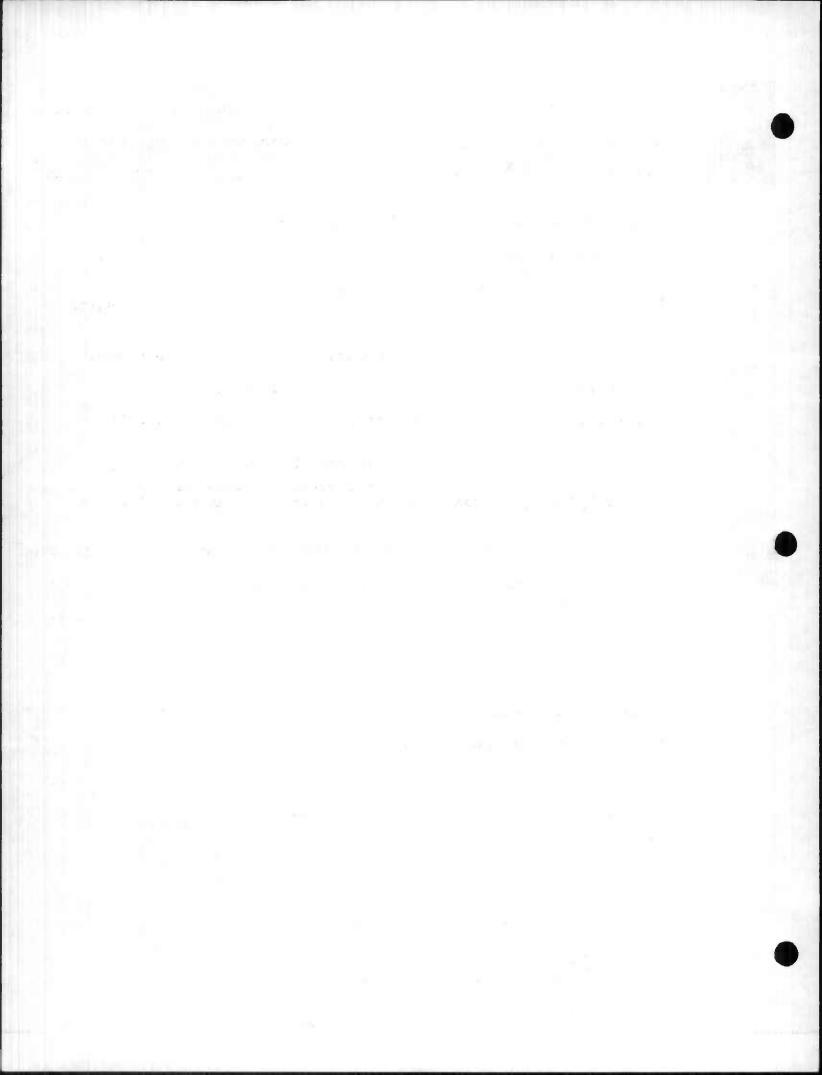
BALTIMORE MD 21201



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Jan. 3, 1999 Naomi Rebecca Tall 5:25 am /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Chesapeake Woods Center Cambridge Dorchester If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Yaar 6. Sex 7. Age (In yrs. last birthday) Birthplace (Steta or Foreign Country) **Funeral** 1 M 2 KF Months Days Yrs. Director 212-18-6918 76 Oct. 15, 1922 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hams 23s or 28a-1 show the Medical Examiner must be notified at 1 ☐ Yas 2 X No Director Maryland Dorchester Fishing Creek 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 2731 Hoopers Island Rd. 21634 U.S.A. Funerai 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Yeer or Dates: b Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify. 3 N Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busineas/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked oths any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Tolley Grace Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) N. Dale Tall / Son 4 Hunter Court, Timonium, MD 21093 20a. Mathod of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Burial 2 Cramation 3 Removal from State
4 Donation 5 Other (Specify) Dorchester Mem. Pk. 01-05 | Cambridge, MD 22. Name end Address of Facility
Curran-Bromwell Funeral Home, P.A. 21. Signature of Funeral Service Lice 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line.

Approximately 1. Approximat Approximate Interval Between Onset and Death **Physician** mianaire Tell lymphona /Medical Immediate Cause (Final diseasa or condition resulting in death) Genonin Examiner Due to (or as a consequence of): Physician/Medical Examiner laronary accery Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Diseese or injury that initiated events pue Due to (or as e consequence of) physician e asteoporon Box 68760 that initiated events rasulting in death) Last Dua to (or as a consequence of): for use as 88 ed by the a Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Records, P.O. 23b. Did tobecco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed electrolyte 24a. Was en autopsy peen page 2 certificate 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Aursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation Affer or Attending after death. Director: After d in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide thin 24 hours aft the Funeral Di mpletely filled in Hospital 1 Destrifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as ataled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the Vithin 2 To the Complet 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) m). D50987 30. Name and accress or person who completed cause of death (Item 23e) (Type, Print) Cambridge no 216/3. Ahmed wawaz 105 Aurora swell 31. Date filed (Month, Day, Year) 32. Registrer's Signature State JAN 0 6 1999 Registrar Geneva



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieneg 9 0 9 0

**Physician** /Medical Examiner

Directo

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Be

Adam James Wingate 4a Facility Name (If not institution, give street end number)

1. Decedent's Name (First, Middle, Last)

**JANUARY** 4b. City, Town, or Location of Death CAMBRIDGE

If Under 24 Hrs.

2. Date of Death

Month

3. Time of Death 3, 1999 0755 AM

**Funeral** Director

28s-f

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21215-0020

Baltimore, Maryland

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Division Attending

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Department of Important: If is any injury or o

**Physician** /Medical

Examiner

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Examiner

Physician/Medicai

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Completed

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Certification:

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216-04-1300

Days Months Hours 16

If Under 1 Year

DORCHESTER 8. Date of Birth

(Month, Day, Year)

July 12, 1982 9. Birthplace (Stete or Foreign Country)
Maryland

Usuel Residence of Decedent

5. Social Security Number

10a. State 10b. County 10c. City, Town or Location

7. Age (In vrs. last birthday)

10d. Inside City Limits

Maryland

Dorchester

Cambridge 10f. Zip Code

1 Yes 2 No

10e. Street and Number

5704 Green Cove Rd.

10XM 20 F

21613

10g. Citizen of What Country? U.S.A.

4c. County of Death

1X Never Merried 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12) College (1-4or 5+) 11

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry Cambridge-South Dorchester High School

White

17. Father's Name (First, Middle, Last)

Victor L. Wingate

18 Mother's Name (First Middle Meiden Sumame)

19a. tnformant's Name/Relationship (Type, Print)

Beth McClain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21659 P.O. Box 55, 5808 Puckum Rd., Rhodesdale, MD

Beth McClain Wilson / Mother

20b. Place of Disposition (Name of cemetery, cremetory or other place)

Student

20c. Location - City or Town, Stete

20a. Method of Disposition

1 Burial 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify)

Cambridge Crematory 1-8-99

Cambridge,

21. Signeture of Funeral Service Licenses

22. Name and Address of Facility
Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613

Immediate Ceuse (Finel · HODDININY

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury

that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or es e consequence of):

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings aveilable prior to completion of cause of death?

1 Nes 2 No

1 Nes 2 No

25. Was case referred to medical 1XXYes 2□ No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 5 Pending

Investigation

6 Could not be determined

JAN 0 6 1999

28b. Time of 739A M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE FIXED OBJECT priver of cor, 14PBit with

1-3-99 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) RT943 CAPUISMOYE DOPUMESTER CO

29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Munte

29c. License number OCME

JANUARY 4, 1999

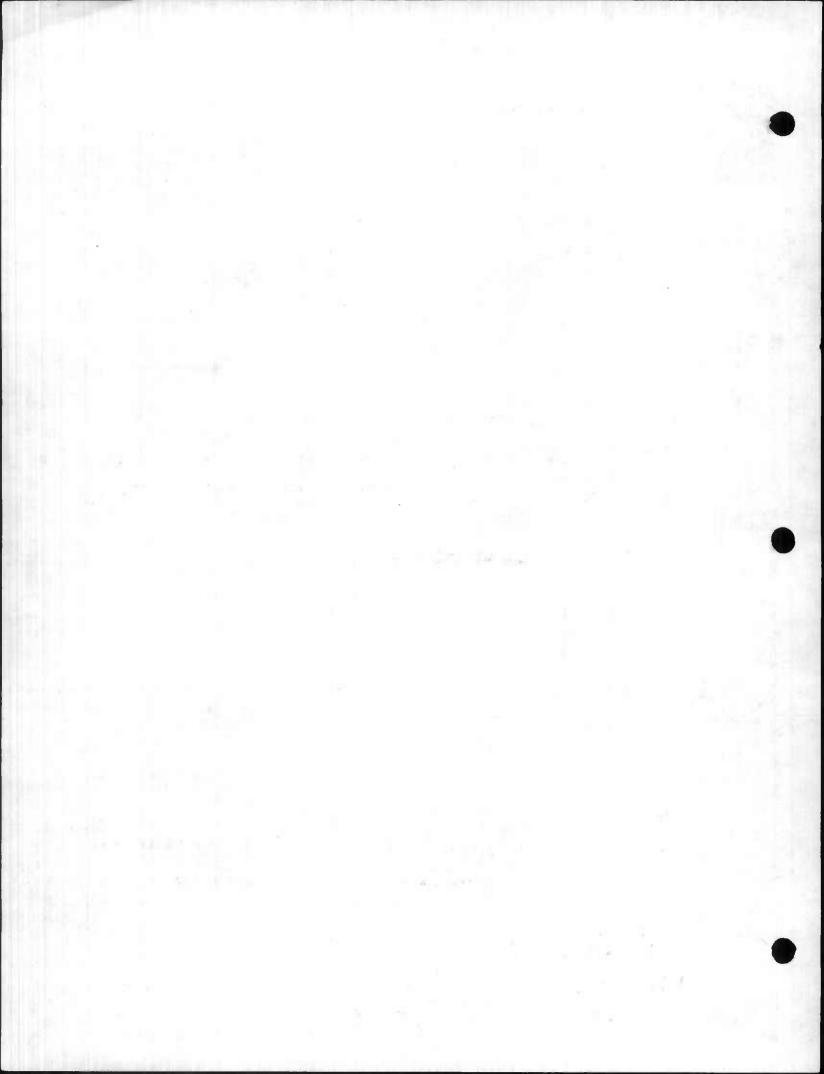
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARLBOUTS 31. Date filed (Month, Day, Year) . Kokik 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature Dener

State Registrar

**DHMH 16 Ray 6/95** 



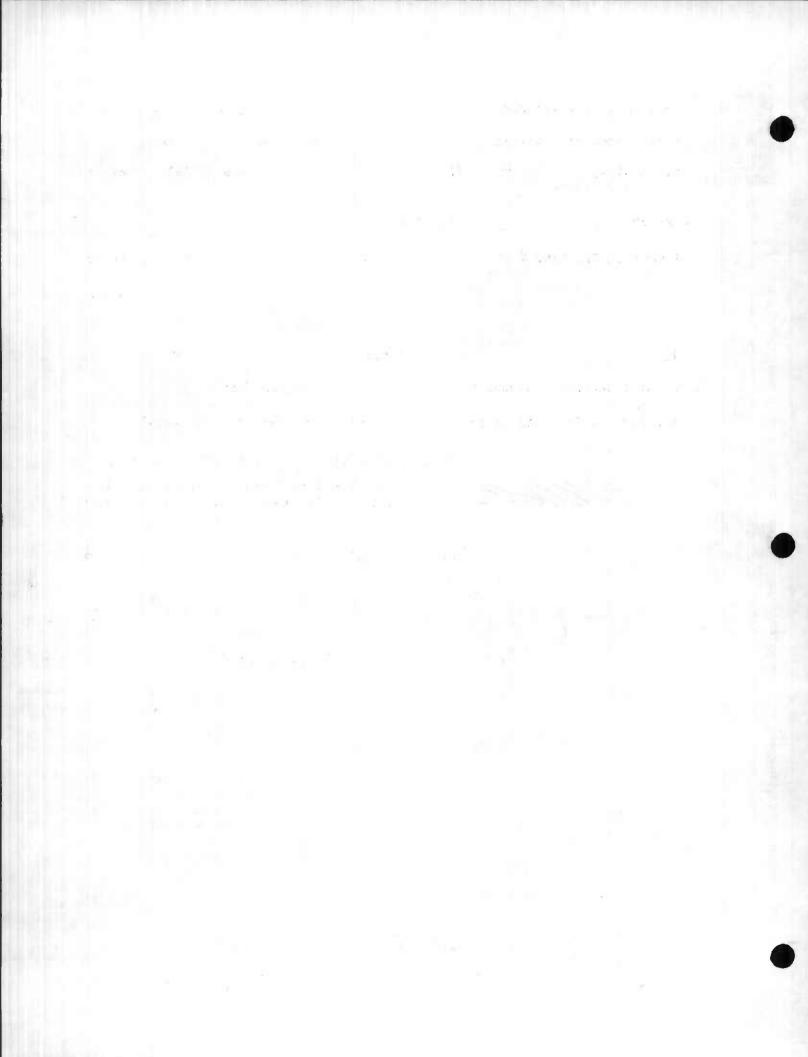
## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Ves **Physician** 1450 PM Mary Carroll Weingarten 1919 02 January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital Baltimore NA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 25 I 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min 1 M 2 XF Months Days Hours Yrs. 62 217-32-7599 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a or 28a-f show any injury or other traumatic event, the Modeal Examiner must be notified at once. 10c. City. Town or Location 10d. inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Directo Maryland NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? # 103 1 Haylock Ct. Apt. 21236 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Unemployed 12th NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Francis Joseph Katzenberger Regina Foote 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence P. Prodoehl (Son) 912 Bobel Dr. Westminster, MD 21157 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 1/5, 1999 Hampstead, MD 22. Name and Address of Facility Burrier-Queen Funeral Directors, P.A. 21. Signature of Funeral Service Licenses. 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of) Cercho vas culer de 980 for signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Ď 24b. Were eutopsy findings available prior to completion of cause of death? should I 24a. Was an autopsy performed? Completed has certificate ha 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Yes 2 No 1 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? After 5 Pending investigation Natural 1 Yes 2 No after death. Director: / 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direc completely filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical (Check only 2 Medical Examiner: On the besis of exemination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated. one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier laman 02 MD ress of person who completed cause of deeth (Item 23e) (Type, Print) TTCY 0 2/2/ 0 31. Dete filed (Month, Day, Year) 32. Registral's Signeture State

**DHMH 16 Rev 6/95** 

Registrar

JAN 0 5 1999



Reg. No. 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Elsie Kral Zdanis January 2, 1999 11:45 P.M. /Medicai 4a. Facility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Copper Ridge Carroll Sykesville If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖫 F Months 212 03 9916 88 Director March 22, 1910 Maryland Usual Residence of Decadent with the Maryland 10a. Stata 10c. City, Town or Location 28a-f show 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examener must be notified at Md. Carroll 1 Yes 2 No Director Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 710 Obrecht Road death v 21784 U.S.A. Funeral Was Decedent Ever in U,S. Armed Forcas? 14. Raca - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give altimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: 29 3 ₩ Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Secretary permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middla, Last) Be Frank Kral Mary Sadelick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) Richard A. Zdanis (Son) 2723 Belvoir Blvd. Shaker Heights, Ohio 44122 20b. Place of Disposition (Nama of cemetery, crematory or other place)
St.Michaels Cemetery 20a Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from Stata 1/6/99 Popular Springs, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensee 22. Nama and Address of Facility Sykesville, Md. 21784 Haight Funeral Home & Chapel P.O.Box 195 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or her a failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final neumonia disaase or condition rasulting in death) Examiner Examiner Highermer's type Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last pue the burial-tran Due to (or as a consequence of): certificate be execu P.O. Box 68760. physician Physiclan/Medical Dua to (or as a consequence of): USB BS attending for signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 SNo 3 Probably 4 Unknown Records, p been sig 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 s has 1 Yes 2 ANo 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician:
 4 hours after death.
 Funeral Director: After this certifical director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not ba 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hou To the Fune completely fi 29b. Signature and title of certified 29c. Licensa number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 710 Obrecht SKESVILLE

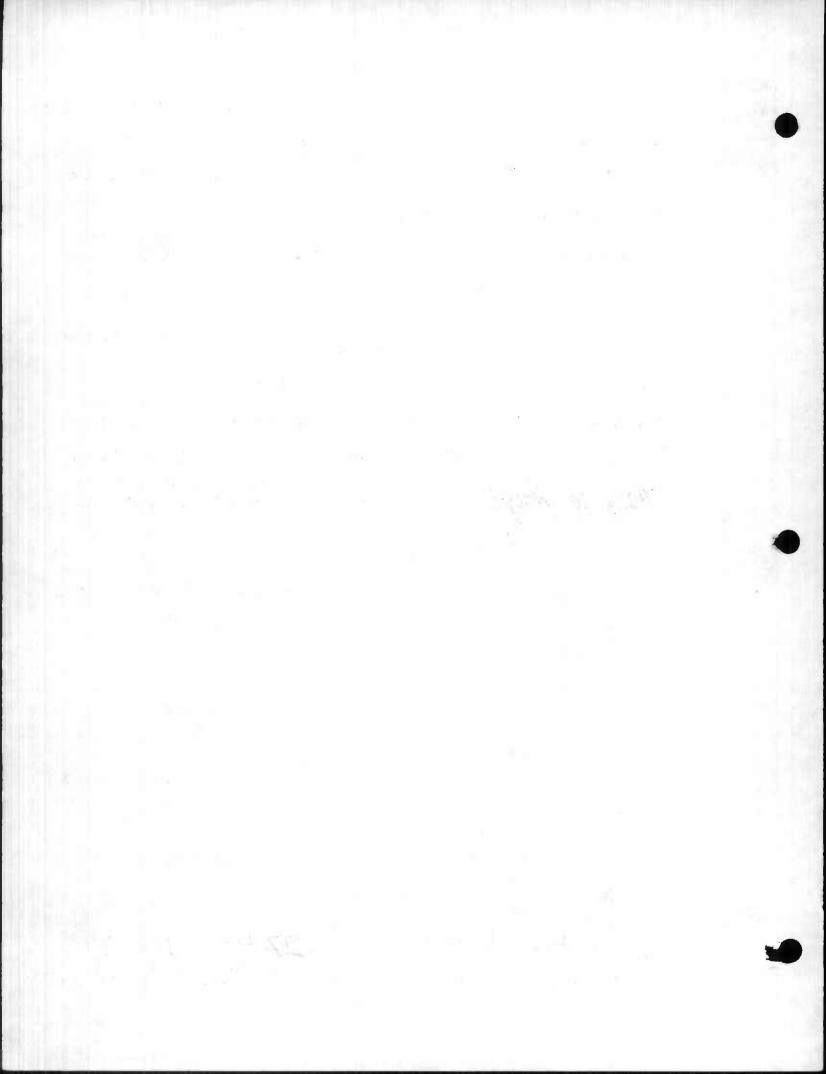
State Registrar 31. Date filed (Month, Day, Year) JAN 0 5 1999

ERNESTINE WRIGHT. 32. Registrar's Signature

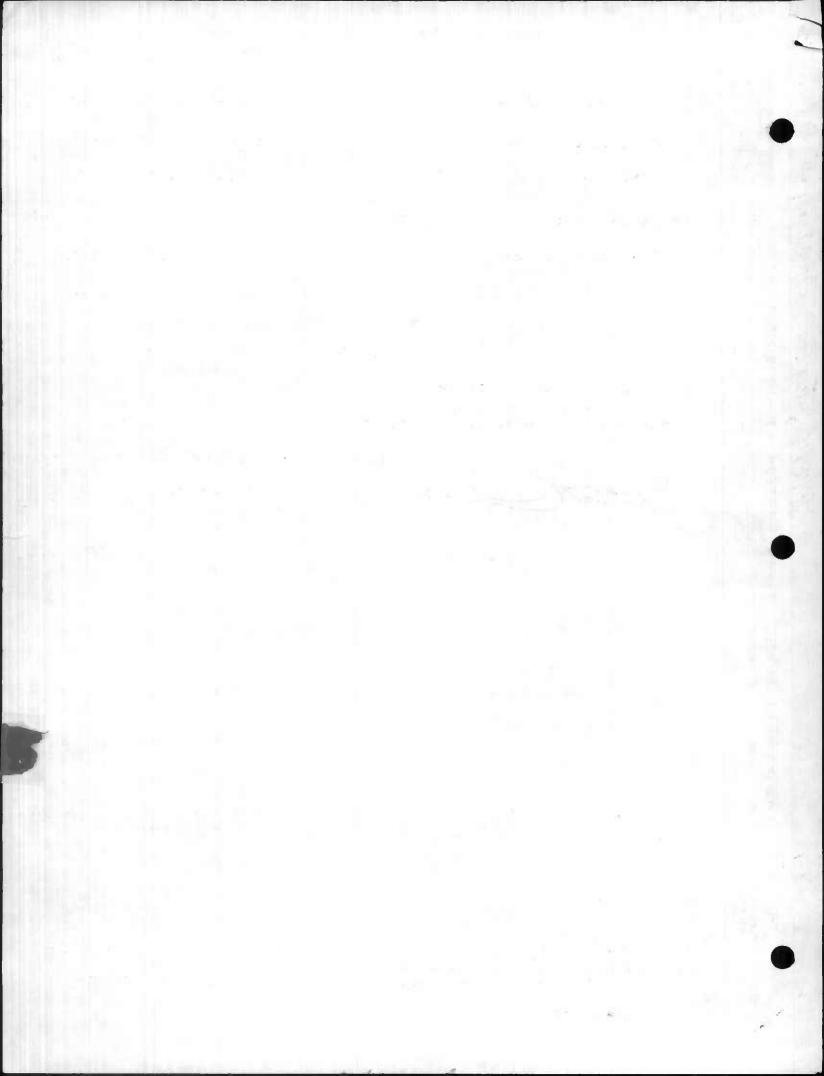
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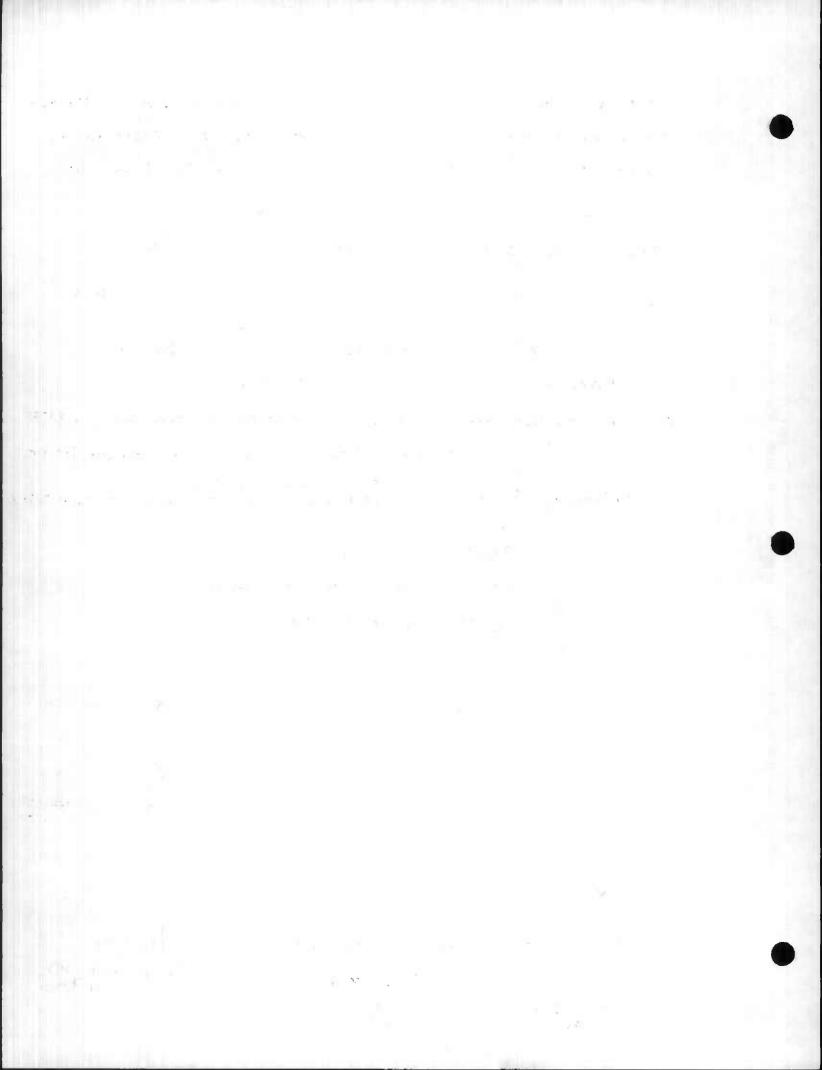
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death 15 Day 1999ar Jan. Mae **Physician** Janet Allers 6661 10:10 PM /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nama (If not institution, give street end number) Examiner Baltimore Gilchrist Center Towson Hours Min. 8. Data of Birth (Month, Day, Yaar) April 24, 194 Birthplaca (State of Country) April 24, 194 Maryland If Undar 1 Year Months Days 5. Sociel Sacurity Number 10 6. Sax 7. Aga (In vrs. last birthday) Birthpiaca (Stata or Foraign Country) **Funeral** Months 1□ M 2X F 55 212-40-3593 Director Usuai Rasidence of Decedant January the Meryland 10c. City, Town or Location 10d. Insida City Limits 10a Stata 10b County "natural", or items 23s or 28s-f show 1 Yas XIX No Director Harford Fallston Maryland 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? with 2305 Oakmont Road 21047 United States Funeral 72 hours after deeth 14. Race - Amarican Indien, 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11 Marital Status Black Whita atc 1 Navar Marriad 2 Married White 1 Yas X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry the Medical Allers, Janet than Elementary/Secondary (0-12) Collega (1-4or 5+) Housewife Own Home 12 marked other 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) permit. Pages 1 and 2 should be Department of Health and Mental Important: If tem 27 Is marked of Etta French William Nelson Knickman 19a. Informant's Nama/Ralationship (Type, Print) Spouse 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) William A. Allers, 2305 Oakmont Rd. Fallston, Maryland 21047 Jr. 20b. Place of Disposition (Nama of cematary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data XXBurial 2 Cramation 3 Ramoval from Stata 6 Mt. Olivet Cemetery 1/20/99 Baltimore, Maryland 4 ☐ Donetlon 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility of Funeral Seprice Licenser Ambrose Funeral Home, Inc. Arbutus 21227 1328 Sulphur Spring Rd. Arbutus, Maryland Approximate interval Batween Onset end Deeth fart1. Entar tha diseasa, or complications that caused tha death. Do not antar the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical immediata Causa (Final Lung concer 3 months diseasa or condition rasulting in daath) Examiner Dua to (or as a consaquance of) Examine The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or Injury that initieted avents rasulting in daath) Last and Dua to (or as a consaguanca of). physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): ettending p SE 23b. Did tobacco use contributa to the csusa of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 94 signed by 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy final available prior to completion of caus of death? should I 24a. Was an eutopsy performed? Completed has 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate Physician: Be 25. Was casa rafarred to madical 28. Plece of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) Hospice 1 Yas 2 No To this 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Daath 28d. Dascribe how injury occurred Certification: After t or Attending 5 Pending investigation 1 Natural safter death.
I Director: Aft
d in by the fur 1 Yes 2 No 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At homa, farm, straet, factory, offica building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and mannar es stated.
2 Madical Examinar: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and mannar stated. edical 29a. Certifian (Check only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 29c. Licansa number D25205 JANUARY 16, 1999 elev. mo 30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print) W. A. Riley BALto Md 21204 6701 N. Charles St. mD G-BMC 31. Date filed (Month, Dey, Year) 32 Registrar's Signatura State JAN 2 0 1999 Registrar DHMH 16 Rev 6/95



### Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Jennie C. Bulman 15, 1999 12:35a.m. Jan. /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6703 Forest Hill Drive University Prk Prince George If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Sept. 20, 1907 5 Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys Months 1□M 2\ F Hours New York 91 Yes 076-44-1746 Director Usuel Residence of Decedent the Maryland 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Warren Lake George N.Y. 1 □Yes 2 □ No Director 10e Street end Number 10f Zip Code 10g. Citizen of Whet Country? with 12845 USA 183 Assembly Point Road Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Merried 2 Married altimore. Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White 2 3 Widowed 4 □ Divorced Yeer or Dates: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) . Peges 1 and 2 should be fill iment of Haalth and Mental H tant: If item 27 is marked out Be Richard Osborne Albina Roy 0 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 6703 Forest Hill Drive, University Park, MD 20782 Patricia A. Bulman/Daughter 20b. Plece of Disposition (Name of cemetery, crematory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 KBurial 2 ☐ Cremetion 3 KRemovel from Stete permit. Pege Department of Important: If any injury or 1/21 Evergreen Cemetery Lake George, New York 4 Donetion 5 Dother (Specify) 21. Signature of Foreral Service Licensee, 22. Name end Address of Fecility Fleck Funeral Home, Inc. M 7601 Sandy Spring Road, Laurel, Maryland 20707 23e. Pert1. Enter the disease, or confplications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart feilure. List only one cause on leach line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel ADVANCED AGE diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Physician/Medical Examiner CONGESTIVE HEART FAILURE burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): and certificate be axec ARDIOMYO PATHY P.O. Box 68760, physician Due to (or es e consequence of) tha usa as attending | Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? deteched been signed by tha should be deteched 1 Yes 25 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? Completed paga 2 s hes 1 ☐ Yes 2 No 1 ☐ Yes Division of Vital diractor, 25. Wes cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Daughter's Hospitel: Other: 4 Nursing Home 5 Residence KXOther (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this Residence 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After t 5 Pending Investigation il or Attending s after death. ii Director: Aft 1 Yes 2 No 2 ☐ Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in by 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is edicai 29e. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the bests of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier collinge 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Ave \$ 509 Baltimore DENIND MEHTA M-1100 31. Dete fited (Month, Day, Year)

JAN 2 0 1999 32. Registrar's Signeture State Registrar



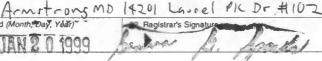
Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** 19, 1999 John В. January 8:25 a.m. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Mariner Health Care of Greater Laurel Laurel Prince George If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1XXM 2□ F 578-20-9588 Director May 4, 1923 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes > No Directo MD Howard Savage 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8805 Baltimore Street 20763 USA should be filed within 72 hours after death nd Mental Hygiene. marked other than "natural", or items 23 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1X Yes 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorcad Year or Dates Completed 15. Decadant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collage (1-4or 5+) Ø Store Keeper State Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If fem 27 is marked othe any Injury or other traumatic event, once. 18. Mother's Name (First, Middla, Maiden Sumame) 17. Fathar's Nama (First Middle Last) John K. Brann Land Dora Wines 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ratationship (Type, Print) Virginia H. Brann/Wife 8805 Baltimore Street, Savage, Maryland 20763 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Dennation Fort Lincoln Cemetery 1/22 Brentwood, Maryland 22. Name and Address of Facility 21/Signature of Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Interval Between Onset end Death **Physician** /Medical Immediata Causa (Final effects ate disease or condition resulting in death) Examiner Examiner physician and the bunal-transit The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disaasa or Injury that Initiated avants rasulting in death) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) as ettending 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. the signed by t d be detach 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen completion of cause of death? certificate has or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 0 1 Inpatient 2 ER/Outpetient 3 DOA After this 27. Manner of Death . Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: 5 Pending invastigation To the ricepow. Within 24 hours after death.

To the Funeral Director: After the Funeral history in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyelclan: To the best of my knowledga, death occurred at the tima, data and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

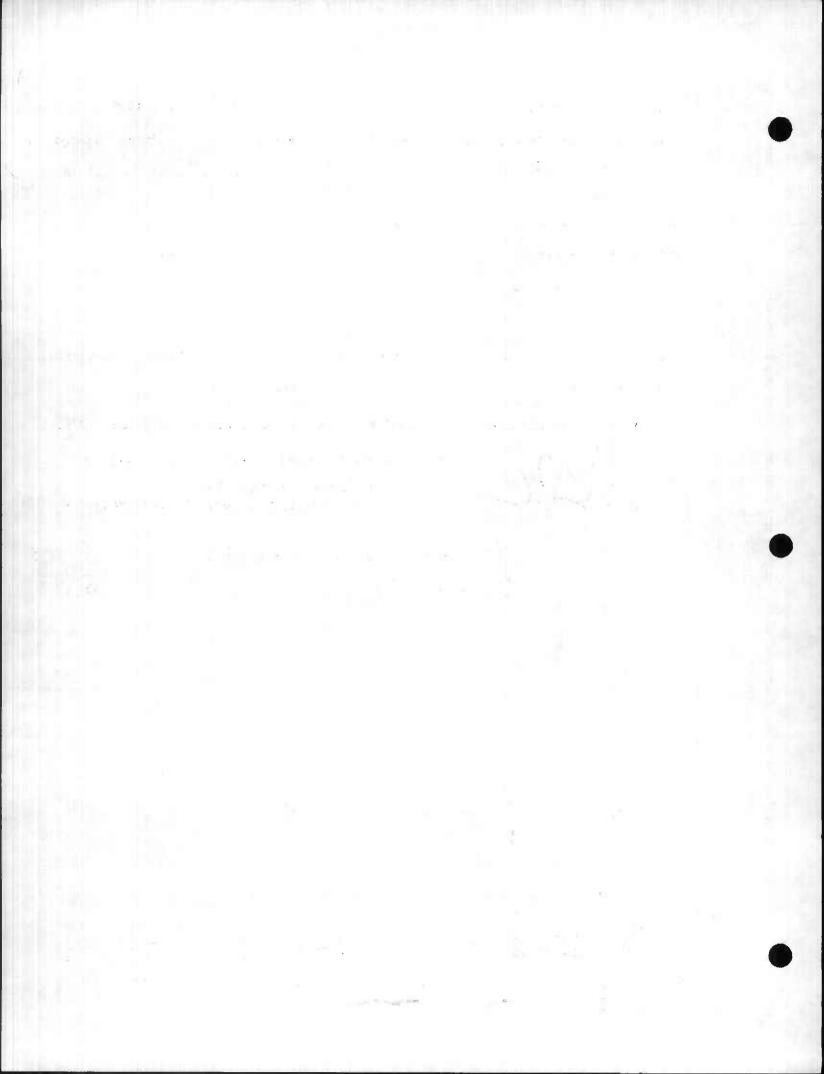
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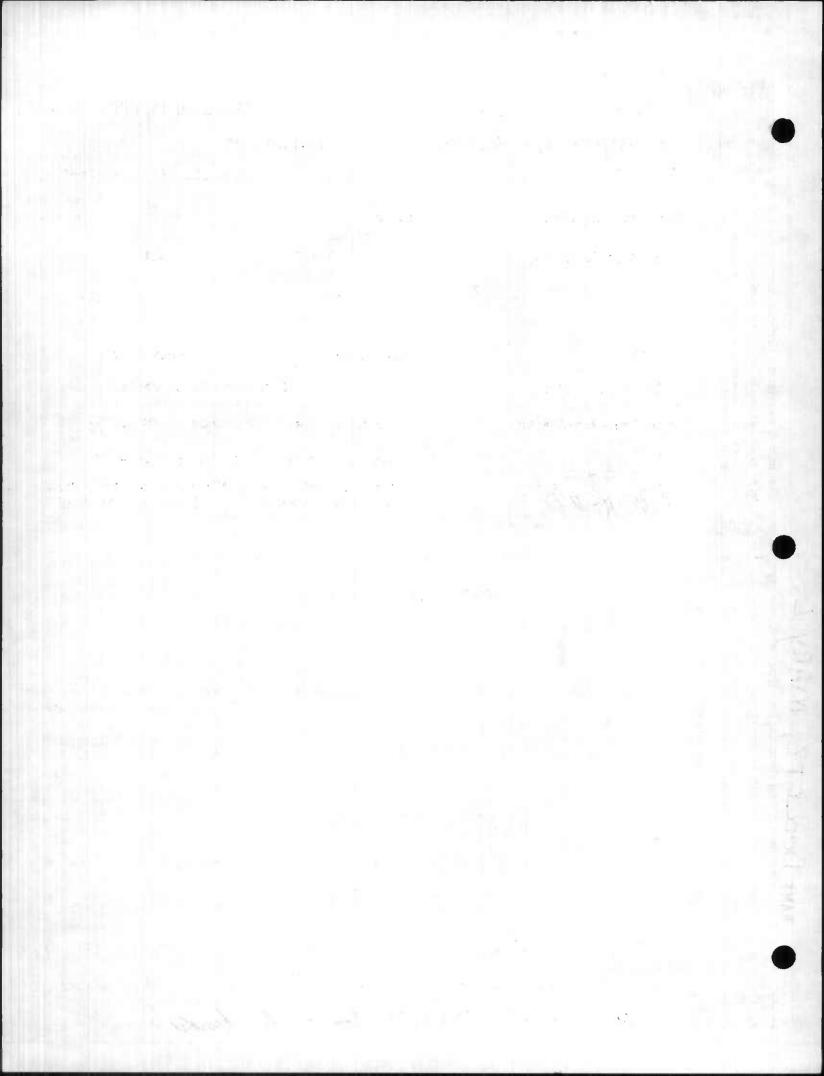


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Item: 31 per V.R 1/20/99 reb Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month
Tanuary 15, 11, 14c. County of Death Physician 15, 1999 BOBL MARY /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) Examiner Healthdare Do If Under 1 Yeer If Under 24 Hrs. 8, Da 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M ACKE 220-22-5222 69 Yrs. Feb. 13, 1929 Director Maryland Usual Residence of Decedent the Maryland r 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Raltimore 1 Yes 2000 Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d 2 should be filed within 72 hours efter death with hit and Mental Hyglene.
7 Is marked other than "neturel", or frems 23a or traumatic event, the Medical Estating manage. 4318 Leola Avenue 21227 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo if Yes, Give Year or Dates: 14. Race - American Indian. 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Recycling Secretary 18. Mother's Name (First, Middle, Malden Surneme) 17. Father's Name (First, Middle, Last) Be Catherine M. Cookerly Albert J. Decker 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Interment's Name/Relationship (Type, Print) Pages 1 end 2 sinent of Health an ant: If item 27 lar ury or other traus Baltimore, MD 21227 Jean Robinson/Sister 4318 Leola Ave. 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of important: If eny injury or 1/18/99 Meadowridge Mem. Park Elkridge, MD 22. Name and Address of Facility Gary L. Kaufman F.H. @ Meadowridge Mem. Park, Inc ease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory arrest, ire. List only one cause on each line. Elkridge, MD 21075 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final BLEEDING ESOPHAGEAL TUMOR disease or condition resulting in death) Examiner Examiner METASTASIS physicien and the burial-transit Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or es e consequenca ot): 88 esn 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was en autopsy page 2 1 Yes 20 No 1☐ Yes 2☐ No certificata NAME BOBLE Attending Physician: 25. Was case reterred to medical exeminer? Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA this 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 1 Netural 2 Accident 5 Pending 1 Yes 2 No investigation after deat 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide ò 24 hours 29e. Certifier 1 🖔 certifying Physician: To the best ot my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completaly fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Mandeep 900 Caton Aherho Dourdh 31. Date tiled (Month Day, Year) 32. Registrar's Signature

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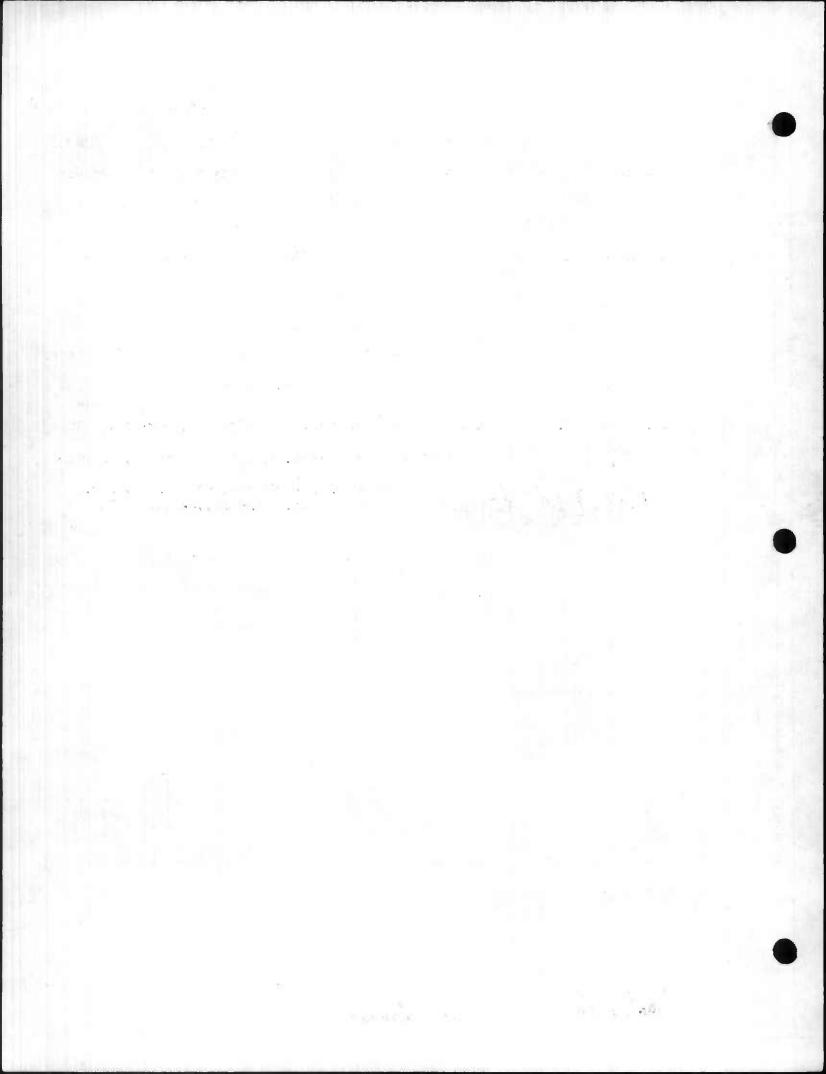
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	Decedent's Name (First, Middle, La	State of Maryla		ificate of			Reg. No.	0 0 9 0 7	
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and within 72 hours after death with the Maryland Pysins of them 22s or 28s I show the Markenia Exemples of 28s I show the Markenia Exemples of 28s I show Completed by Funeral Director	4a Facility Name (If not institution, give street and number)  FRANICUM SQUARE HOSPITAL CEM  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un Montl  217-14-7624 19 M 20 F 77 Yrs.				4b. City, Town, or  POSE If Under 24 Hrs Hours Min.	DACE 8. Date of Bir (Month, Di	B	of Death  A CT I NO LE  9. Birthplace (State or Foreign Country)  Baltimore	
	Usual Residence of Decedent  10a. State 10b. County	10c. C	10c. City, Town or Location					10d. Inside City Limit	
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	8049 Kimberly Roa	ıd		10 2.0	21222			States	
	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1942	11		lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)	Specify	e - American Indian, sk, White, etc.  White	
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iit. Pages 1 ind 2 atment of Health a artent: if feen 27 is injury or other tra	Mrs. Rebecca J.  20a. Method of Disposition  1	Removal from State	Place of Disposicemetery, crematilitop	tion (Neme of atory or other place Service	Corp. 1/	Dete	20c. Location -	land 21222 City or Town, Stata n, Maryland	
certificate be executed ding physician and limper use as the burist-transit amy in any	22. Name and Address of Facility  Duda-Ruck Funeral Home of Dundalk, Inc.  7922 Wise Ave. Dundalk, Maryland 21222  23a. Part1. Enter the disease of Completation of the Caused the Beath Shock, or heart failure. List only our day on each line.  Approximate Interval Between Consett and December 1.								
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10-11	30. Name and address of person who	completed cause of death (Ite	em 23a) (Type, P	rint) 9000 L	CLALVI	iki CA	DP A	ALTO, NO 2 123	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	pature /	11	11/2/20	11- 24	VI- 01	1-10/11/4 4 182	



State of Maryland / Department of Health and Mental Hygiene 9

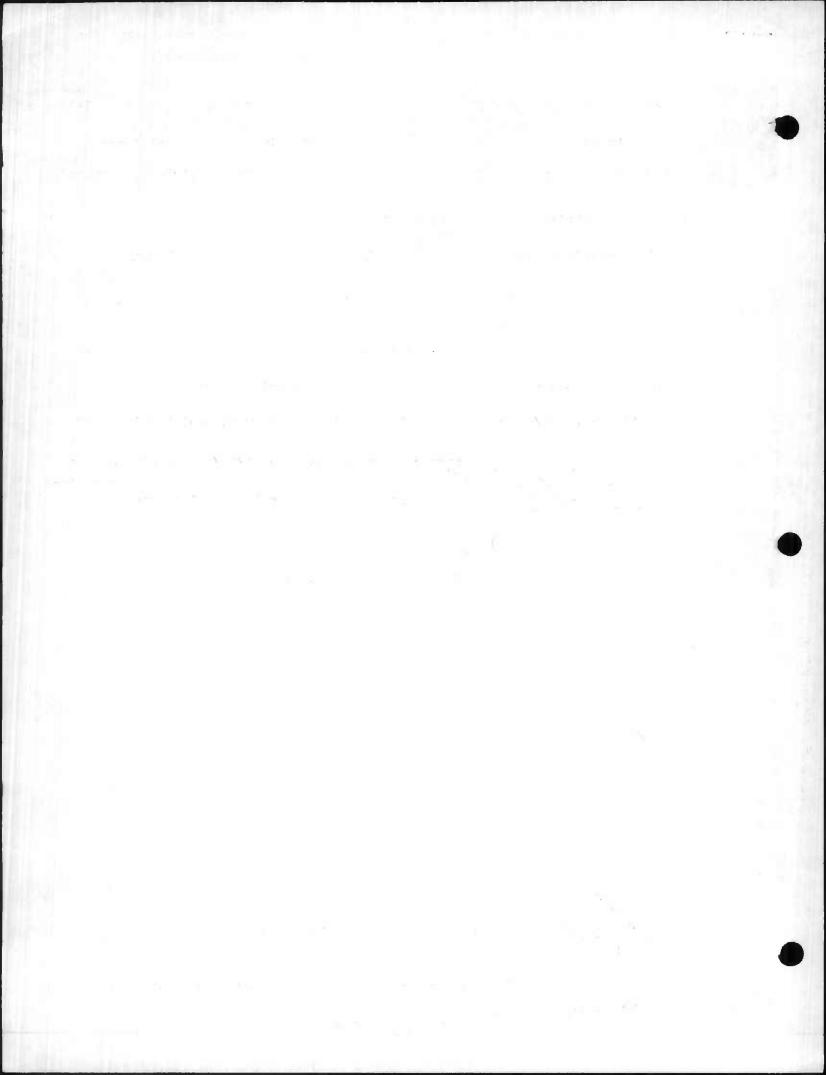
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Registrar

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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM: #1 PER MD G769 3-5-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARIE Month Year **Physician** JANUARY 16 5:28 AM MARY BARBARA CHIPMAN 1999 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OAK CREST VILLAGE CARE CENTER PARKVIUE WUnder 24 Hrs. 8 Da BALTIMORE If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 1 M 2 3 F Days Hours Min. 571-34-4131 AUG . 30, 1918 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Directo BALTIMORE PARKVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? EM. 222 21234 8832 WALTHER BLVD. U.S.A . Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Maritai Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: by 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 MACHINIST BLACK & DECKER CO. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 JOSEPH PARR ELEANOR RUSSELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) GUEN ARM MO. 21057 MARY LEE AGEE, DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition Date JAN. 19, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 1999 PARKVILLE, MD 21. Signature Truneral Service Licensee 22. Name and Address of Facility EVANS CHAPEL OF MEMO RIES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) 2 DAY Due (d) (or es a consequence of): Examiner ZDA Neumonia Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence ot): Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributi q death but not resulting lrythe underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending Investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29b. Signature and take of certified 29d. Daje signed (Month, Dey, Year) reduce

State Registrar

**Funeral** 

**Director** 

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**Physician** 

/Medical

Examiner

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PARKVILLE, MD. 21234

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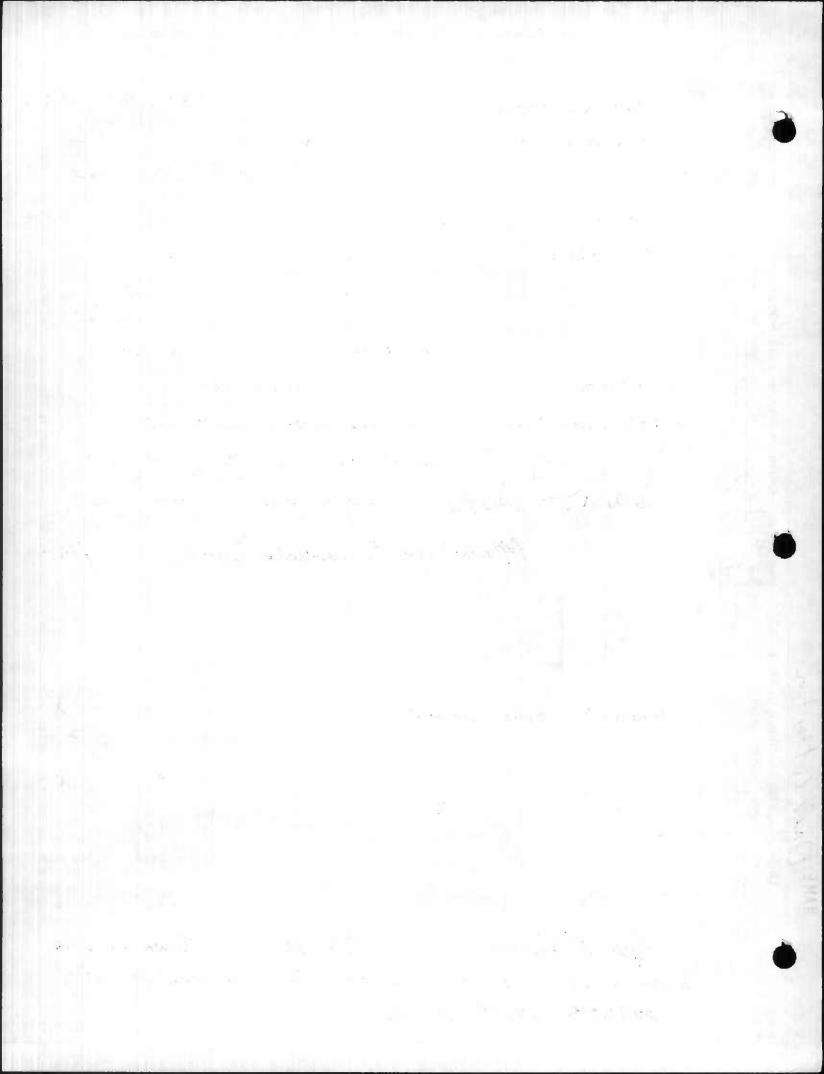
### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death JANUARY DAYS, 1999 **Physician** 23:02PM Elmer Leroy Catterton - /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner St. Agnes Hospital Baltimore 5. Social Security Number If Under 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** 1₽M 2□F Months Days Hours Min 212-01-9931 Yrs 89 1909 Director July 6, Delware Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Maryland Baltimore Arbutus Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1330 Birch Avenue 21227 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Black, Whita, etc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If them 27 Is marked other than "natural", or ite 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify White h 3 ∰ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondery (0-12) College (1-4or 5+) Tool & Dye Manufacturing 18. Mother's Neme (First, Middle, Malden Sumame) 17. Fether's Neme (First, Middle, Last) Mervin Catterton Lillian Hershey 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Bruce Catterton (Son) 1330 Birch Avenue Arbutus, MD 21227 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 12 Buriel 2 ☐ Cremation 3 ☐ Removal from State 6 4 □ Qonation 5 □ Other (Specify) Meadowridge Memorial Park 1/21/99 any injury Elkridge, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD 21227 23a. Pert1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. . Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Intervel Between Onset end Deeth **Physician** Atheroscientic Carlovascerlar Disease Immediate Ceuse (Finel disaese or condition resulting in death) /Medical Examiner Examiner the attending physician and hed for use as the burial-trans Sequentielly list conditions, if eny, leeding to immadiata cause. Enter Underlying Cause (Diseese or injury that Initieled events rasulting in daeth) Last Due to (or es e consequence of): Physician/Medical Dua to (or as a consequenca of): NAME Muss Catterton Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown anew ysm 2g 24e. Was an autopsy performed? 24b. Wera autopsy findings eveileble prior to Completed completion of cause of deeth? After this certificate has 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 27. Manner of Deeth 28d. Describe how Injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et tha time, dete end plece, end due to the cause(s) end menner es stated. Medical 2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29c. License number 29d. Deta signed (Month, Day, Year) 29b. Signatury and title of certif 30. Name and ecoress of person who completed cause of deeth (item 23e) (Type, Print) Bultimore Moryland Avenue 900 Caton EVIN H. SCRUGES MID 31. Dete filed (Month, Day, Year) 32. Registrer's Signature

Registrar DHMH 16 Ray 6/95

State

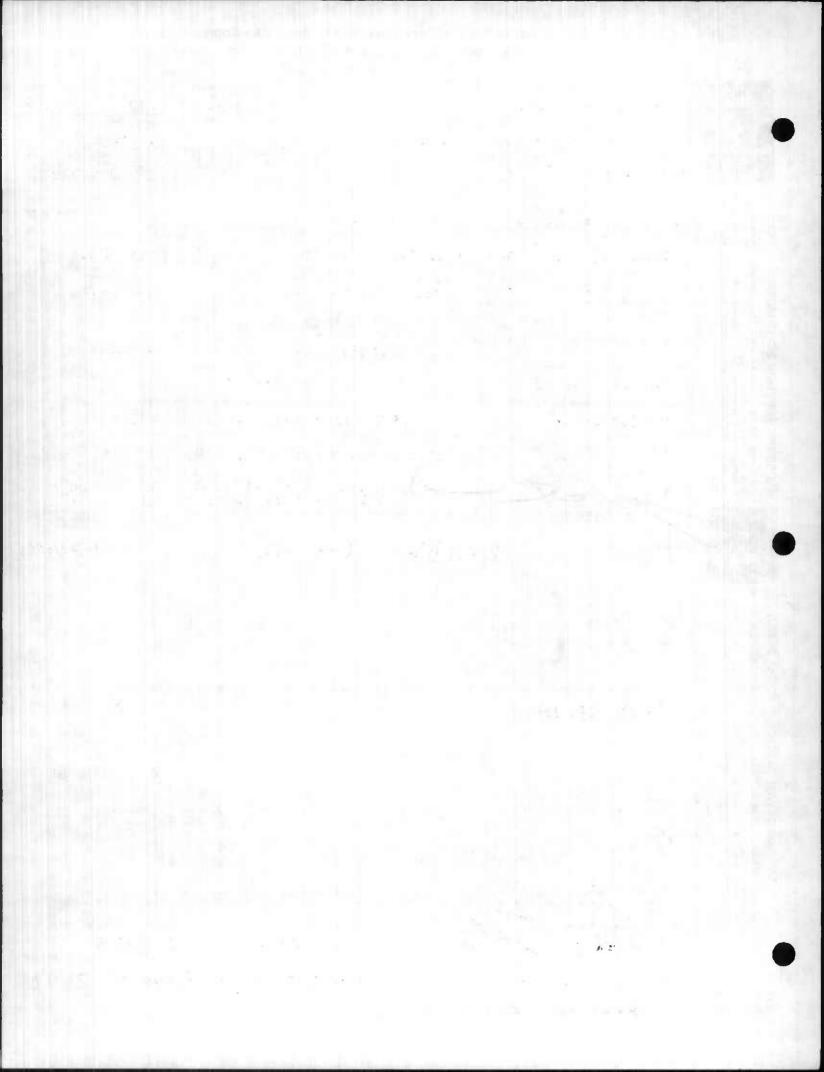
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State of Maryland / Department of Health and Mental Hygiene

			(	Certifica	te of	Death		leg. No.	00311	
Physician	1. Decedent's Name (First, Middla, Last)						2. Date of Dea Month	Day Ye	3. Time of Death	
/Medical	Edward Orr	Carter						1999		
Examiner	4a Facility Name (If not institution, g					4b. City, Town, or		4c. County of C		
		ta Road	Apt.			Lansdo		Balti		
Funeral Director	5. Social Security Number 6. 258-44-8583 Usual Residence of Decedent	Sex XXM 2□F	66 Y	day) If Und Months	Days	Hours Min.	8. Date of Birth (Month, Day Jan 2	Year) 9.	Birthplace (Stata or Foraign Country) Georgia	
72 hours after deeth with the Maryland natural, or items 23a or 28a-f show ord Exercises must be notified at each of by Funeral Director	10a. State 10b. County	87777	10c. City, Town	or Location					10d. Inside City Limits	
	Maryland Balt	more Lansdowne			ne				1 ☐ Yes 🎎 No	
	10e. Street and Number			log. Citizen of Wha	t Country?					
	2404 Tiones	ta Rd.	Apt. 2	-B	212	27		United	States	
	11. Marital Status	12. Was Decedent Armed Forces?			edent of I	t of Hispanic Origin? (Specify Yes Cuban, Mexican, Puerto Rican, e		14. Race - A	American Indian, White, etc.	
	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced		1962	1□ Yes				111111111111111111111111111111111111111	White	
"natural", solical Exe leted by	15. Decedent's (Specify only highast g		16a. I	Decedent's Us	ual Occup	pation	rkina	16b. Kind of Busin	ess/Industry	
ygiene. Nor than "natura It, I're Woolcal Completed	Elementary/Secondary (0-12)	College (1-4or 5		lifa. DO NOT	usa <i>retire</i>					
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T S O	17. Father's Name (First, Middle, Las	t)						Maiden Sumame)		
marked o	Robert Cart	er				Leeta	Orr			
end is me	19a. Informant's Name/Relationship	(Typa, Print)	19b.	Mailing Addre	s (Street	t and Number or Au	ıral Routa Numbe	r, City or Town, Sta	ta, Zip Coda)	
alth 27 i	David Carter	/ son		3600 I	ila	c Ave.	Lansdov	ne, Md.	21227	
of Health Itam 27 r other ti	20a. Method of Disposition		20b. Place of I	Disposition (No. crematory of	ama of othar pla	ica)	Date	20c. Location - City	y or Town, State	
_= 0	XOXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec						1/20/99 Glen Burnie, Md.			
Departmen mportant: any injury ance.	21 Signature of Euneral Service Lid		28			ess of Facility Funera	1 Home	of Lans	sdowne21227	
W W W	de	4	-	271	) Ha	mmonds	Ferry I	Rd. Lanso	lowne, Md.	
	Parti. Enter the disease, or con hock, or heart failure. List onl	nplications that caused y one cause on each lir	the death. Do no	ot enter the me	de of dyl	ng, such as cardiad	or respiratory ar	rest,	Approximate Interval Between	
ysician							Onset and Death			
Medical	Immediate Cause (Final disease or condition					NICER		1-2 YEARS		
aminer	resulting in death)	a. Due to (or es a consequence of):						. 27		
ig.	1933		200 10 (01 00 01 01		,					
n and Hal-fransit Examiner	Sequentially list conditions	Due to (or as a consequence of):								
Exa da	it any, leading to immediate cause. Enter Underlying	but to (or as a consequence or).								
physician and s the butal-tra edical Exar	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	cDue to (or as a consequence of):								
4 B	resulting in death) Last	dcontributing to death but not resulting in the underlying cause								
attends for use	Bad II Ottora I a Marana a a Marana					e given in Part f. 23b. D		ofd tobacco use contribute to the cause of death?		
d by the attendir leteched for use Physician/A	Part II. Other significant conditions				cause gr					
dete dete	MIHYSEM	4				10		☐ Yee 2☐ No 3 (\$20 robably 4 ☐ Unknown		
been signed by should be detect						24a. Wes an autops		2	4b. Were autopsy findings	
page 2 should						24a. Wes an autopsy performed?		available prior to completion of cause		
S C C								of death?		
page Con							1 🗆 Y	es 2000	1 ☐ Yes 2 No	
To the Hospital or Attending Physician: The I within 24 hours effer death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com	25. Was case referred to medical					26. Place of De	ath (Check only o	na)		
	examiner?	Hospitel: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 8   Other (Specify)							Specify)	
	27. Menner of Death				28c. Inju	iry at	28d. Describe h	ow injury occurred		
	2 Accident 5 Pending Investigation				Yes 2□No	s 2 □ No  28f. Location (Street and Number or Rural Routa Number,				
	3 ☐ Sulcide 6 ☐ Could not determine	286. Place of injury - At nome, farm, street, factory, office								
	4 Homicide	building, efc. (Specify)					City or Town, Stete)			
	29a. Certifier  Check only  Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ca								cause(s) end menner es stated. dete and place, and due to the cause(s)	
ed ed	one)		manner stated.							
To the com	29b. Signature and title of certifier	19 11 45					29d. Date signed (Month, Day, Year)			
	> ( mise ( 4 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 /				9807	1/18/99				
	30. Name and address of person who completed gause of death (Item 23a) (Type, Print)									
	CARLES L. ZIEEL, M.D. 1406 S. CRAIN HWY tho					JY #106	GIFN	BURNIE N	10 2/06/	
State	31. Date filed (Month, Day, Yaar)	-	ar's Signature,				000,	1	7 0000	
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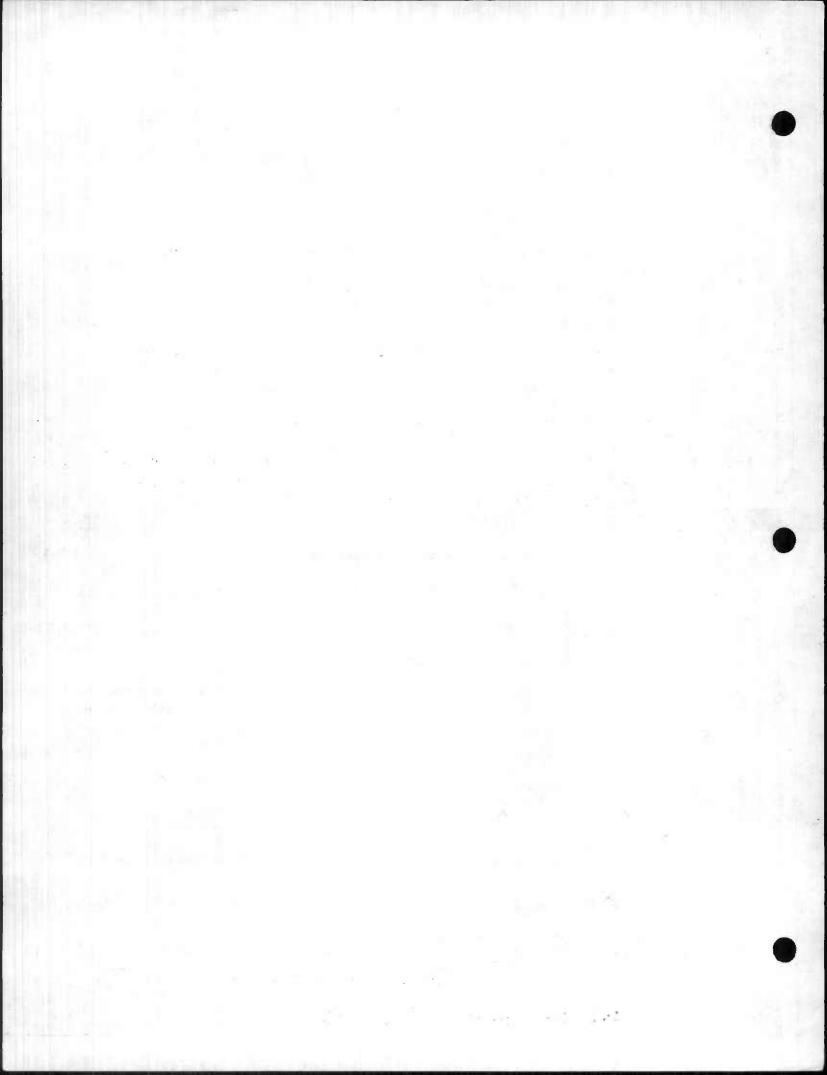
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year **Physician** 300/PM KOBERT COLE 1999 ANUARY 13 /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORECITY HOSPITAL HOPKINS JOHNS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. 726-18-2406 70 Director OK 01-05-29 Usual Residence of Decedent 10b. County 10e State 10c. City. Town or Location 10d. Inside City Limits ahow must be notified at MD NA Baltimore ty yas 2 No Director 288-1 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 'natural', or lisms 23s or 1312 East 35th Street 21218 IISA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? ¹0℃97es 2 □ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Meritel Stetus Biack, White, etc. ahar 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: Black à 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglens. Elementary/Secondary (0-12) College (1-4or 5+) 2yrs. 12th Grade Postal worker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itsen 27 is marked other any Injury or other traumetic event 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) 88 William Cole Velma Graves 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 1312 East 35th Street Baltimore, Maryland Doris Johnson 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20c. Location - City or Town, Stete MD 20a. Mathod of Disposition Purial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest VA Cem. 01-22-99 Owings Mills 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue leren 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift phy one cause on agot line Approximata Interval Between Onset and Deeth **Physician** /Medical Immediata Causa (Finel 2 DAYS CEREBAL EDEMA disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner LIVER END DISEASE 5YEARS STAGE physician and the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or as e consequence of) 30 YEARS Box 68760. HEPATITIS 73 Physician/Medical that initieted events resulting in death) Last Due to (or es e consequence of) for use as 2 YEARS HEPATIC ENEEDHALODATHY 080 detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records. P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed 1 Yes 2 00 No 1 ☐ Yes 2 No certificate Division of Vital director. Be 25. Was casa refarred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No this After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: or Attending 5 Pending investigation efter deeth. I Director: Aft d in by the fun 1 Tyes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) To the Hospital or A within 24 hours effer To the Funeral Director completely filled in by 4 ☐ Homicide edical Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the 29e. Certifie ner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES-000 ANDERY 13,1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOPKINS HOSPITAL A. DIAZ JOHNS LUIS 31. Date filed (Month, Day, Year) 32. Registrer's Signeture

**DHMH 16 Rev 6/95** 

Registrar

JAN 2 0 1999



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 16, 1999 Mary Grace Camponeschi January 12:00 PM 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Franklin Square Hospital Rossville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dev. Year) Birthplaca (State or Foreign Country) Days Months Hours 1 M & F Yrs. Maryland 212-01-1355 Usuel Residence of Deceden 80 10a State 10b. County 10c. City, Town or Location 10d, inside City Limits 1 ☐ Yes 2 No MD Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21236 4 D Haspert Road 12. Was Dacedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3. Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elemantary/Secondary (0-12) Homemaker Own Home 17. Fathar Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Meiden Sumeme) Pietro Silvestri Teresa Betinelli 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a, tnformant's Name/Relationship (Type, Print) 5 Corwen Ct. Perry Hall, Maryland 21128 Jean Temple 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith Cemetery 1/20/99 Baltimore, Maryland 22. Name and Address of Facility Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206 ions that dissed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death immediata Causa (Final diseasa or condition rasulting in daath) years Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaase or injury that initieted evants resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contributa to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown Lailure 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yas 2 No 25. Was casa referred to medical examiner? 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3- DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 28c. Injury at Work? 27. Manner of Death 28a. Date of tnjury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of injury - At home, farm, street, factory, offica building, atc. (Specify) 4 Homicide 29a. Certifiar Escertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar es stated.

physician and the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 98 980 signed by the e certificata has b Hospital or Attending Physician: this After Director: a Funaral Di Funaral Di pletaly filled in

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

**Funeral** 

Director

7 is marked other than "naturel", or flams 23s or 28s-f show treumstic event, the Medical Examiner must be notified at

with the Marylend

permit. Pages 1 and 2 should be filed within 72 hours efter death with Department of Health and Mental Hygiena. Important: If Hem 27 is marked other than """.

Physician

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Examiner

Examiner

Physician/Medical

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Certification:

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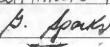
State Registrar

31. Data filad (Month, Day, Year) JAN 2 0 1999

(Check only one)

29b. Signature end title of certiling

30. Nama and address of person who complated causa of death (Item 23a) Brehmo 32. Ragistrar's Signature



2 Madicat Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

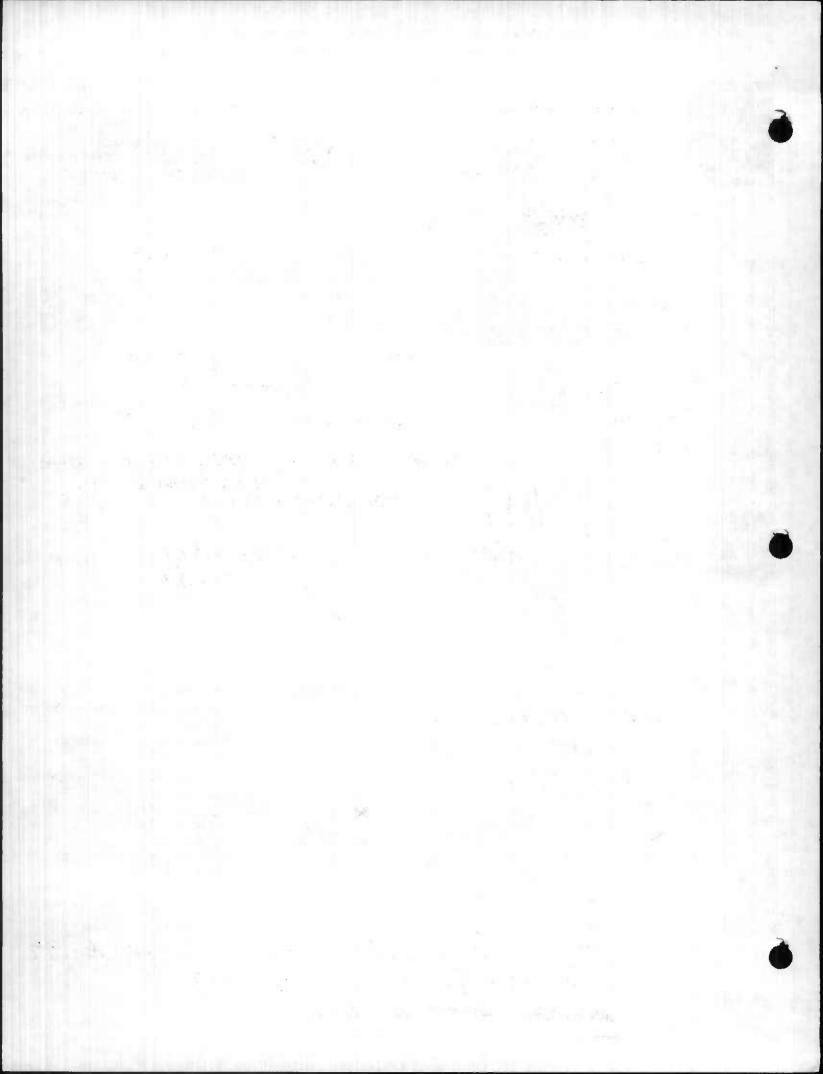
29c. License number

29d. Dete signed (Month, Dey, Year)

January

**DHMH 16 Rev 6/95** 

To the Within 2



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1940 **Physician** Christopher 4b. City, Town, or Location of Death /Medical c. County of Deeth 4a Facility Name (If not institution, give street and number, Examiner Sinai Hospital Baltimore 7. Age (In yrs. lest birthdey) 89 Yrs. Il Under 1 Yaar | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Days 1 M 2 KK 219-22-6023 April 27, 1909 Ga Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. n/a Baltimore 1 No 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1815 Madison Avenue 21217 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Dacedent of Hispanic Origin? (Specify Yas or No-II Yes, specify Cuban, Maxican, Puarto Ricen, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes XXNo If Yas, Giva Year or Dates: 1 Navar Married 2 Married 1 Yes No Specify: Specify: Black p 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) mentary/Secondary (0-12) College (1-4or 5+) Homemaker Private Families 12th Grade 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Mack Gray Eliza Stewart 19e. Informant's Name/Relationship (Type, Print) Grand-19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Charisse A. Walker 4017 Carlisle Avenue Baltimore, Md. 21216 daughter 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Arbutus Memorial Park Jan. 16 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licenses retter 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Tred en 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or haart tailure. List only one causa on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disaese or condition resulting in deeth) a Respiratory Failure Due to (or es a consequence of): Examiner Bilateral Pleural effusions Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence ot): Physician/Medical Pneumonia Due to (or as a consequence ot): resulting in deeth) Last 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Dementia by 24b. Were autopsy findings available prior to completion of causa ot deeth? 24a. Was an autopsy performed? Completed Anasarca 2 1 No 1 Yes 1 Yes 20 No Hypoalbuminemia Be 25. Was casa ratarred to madical examiner? 28. Placa of Daath (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P L 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Sulcide 28e. Place of Injury - At home, larm, street, tactory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) end menner as stated. Medica (Check only 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s)

The law requires that the death certificate be executed Box 68760, Division of Vital Records, or Attending Physician:

**Funeral** 

**Director** 

"natural", or items 23s or 28s-f show adical Examiner must be northed at

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Example page.

Physician /iviedical

Examiner

attending physician and for use as the burial-transit

signed by the a

should b

his certificata has b

this

After

Director: /

24 hours after
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altimore, Maryland 21215-0020

with the Manyland

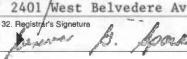
death \

State Registrar 31. Date tiled (Month, Day, Yeer)

David L Meyers,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and little of certifier



West Belvedere Ave. Baltimore, MD

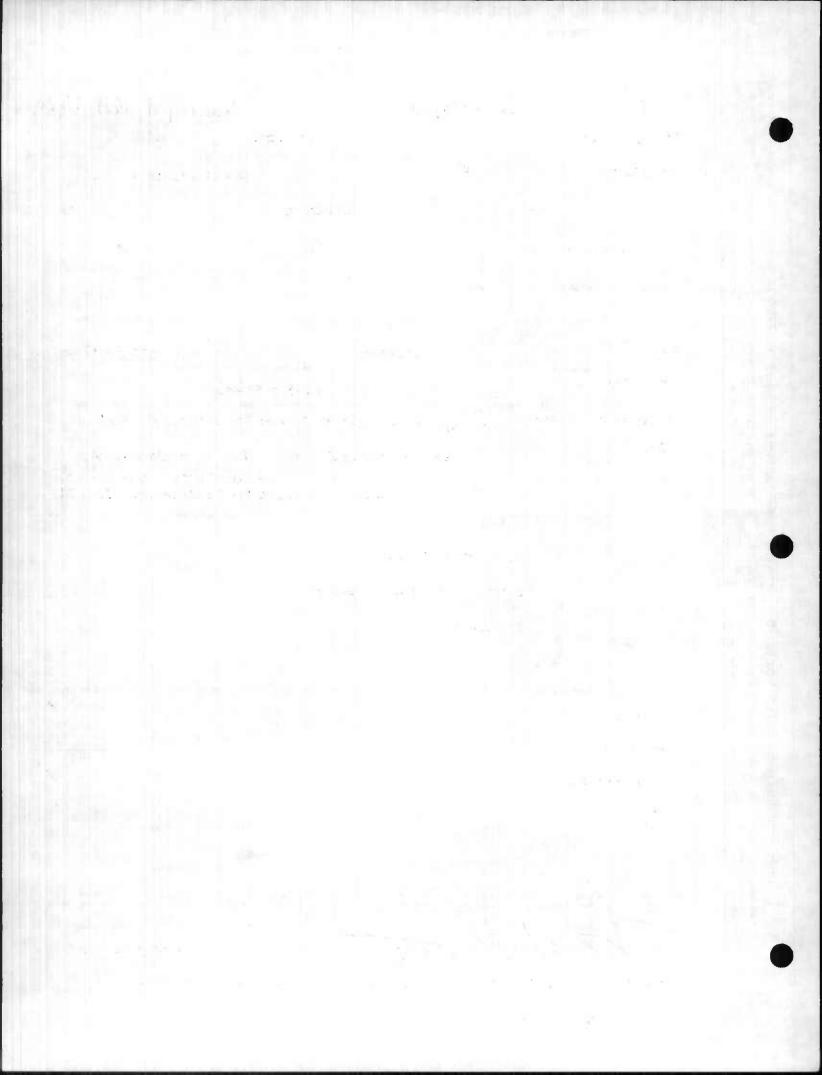
29d. Date signed (Month, Dey, Year)

January 11, 1999

29c. License number

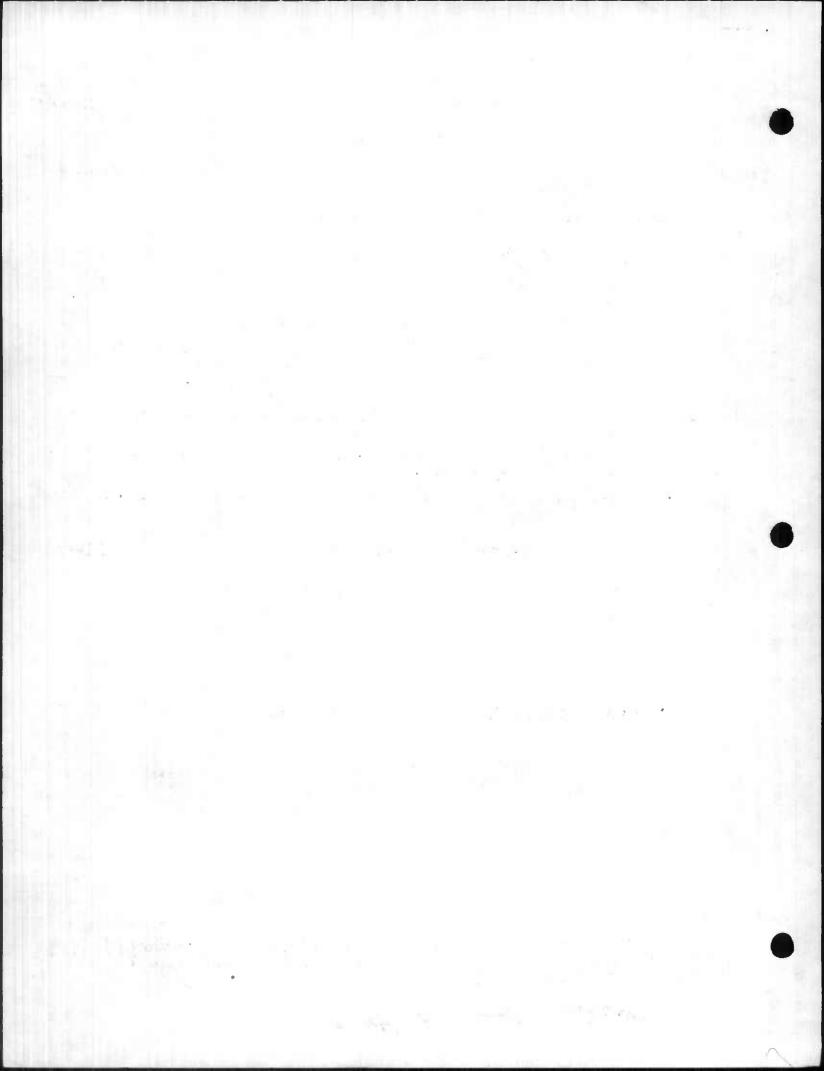
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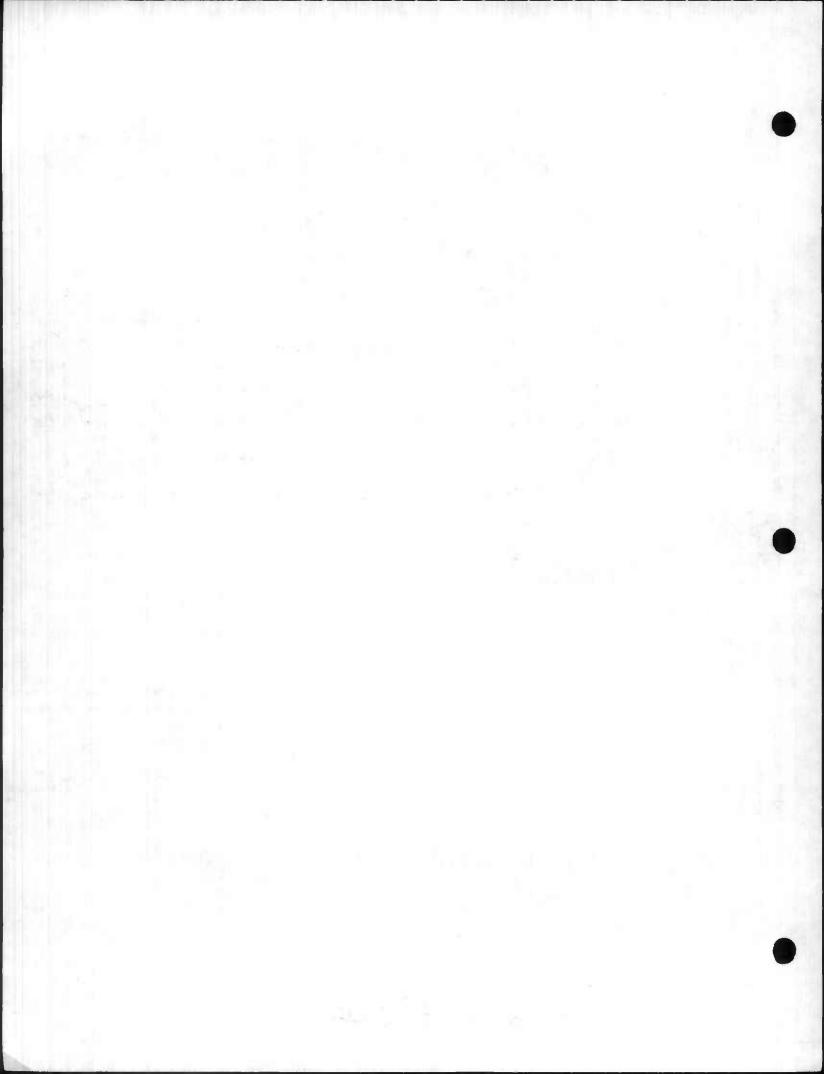
			or maryland	Certificate of L	Death	Re	ig. No.	00915
Р	hysician	Decedent's Name (First, Middle, Last)     The	omas Loo (	Charlton Jr.	1000	2. Date of Death Month	Day Yes	
	/Medical	4a Facility Name (If not institution, give street and no			b. City, Town, or Loca	January ation of Death	18, 1999 4c. County of D	
	xaminer	Baltimore Rehabilitation			Baltimore			N/A
	neral ector	5. Social Security Number 216-16-3821 6. Sex	7. Age (In yrs. last		If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, July 10	Year) 9. E , 1922 Ba	Birthplace (State or Foreign Country)
pu	ž ==	Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits
e Mary	be notified.	Md. Baltimore		Parkv	ville			1 ☐ Yes 2 No
with th	Direct	10e. Street and Number 8627 Richmor	nd Avenue	10f. Zip Code	21234	10	Og. Citizen of What United	
d 21215-0020 filed within 72 hours after death with the Manyland hygiene.	at, or tems 23s or 28s-1 show Examples must be notified at by Funeral Director	11. Marital Status 12. Was Dec	cedent Ever in U,S. orces? 2 No 1942	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Speci n, Mexican, Puerto Ri	ify Yes or No- can, etc.)		merican Indian,
2 hou	natural, or oldal Exam leted by F	15. Decedent's Education	1	6a. Decedent's Usual Occupa	ation		16b. Kind of Busina	ss/Industry
d 21215-0020 filed within 72 hours af Hygiene.	t, the Manical I	(Specify only higheat grade completed Elementary/Secondary (0-12) College	) (1-4or 5+)	(Give kind of work done of life. DO NOT use retired Pattern Maker	)		Beth. Ste	el Co.
D B	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name (	First, Middle, A	faiden Sumame)	
ylan buld be Mental	To B	Thomas Le	ee Charlto	on Sr.	Berth	na F. S	mick	
Mar nd 2 sh lith and	zy is ma	19a. Informant's Name/Relationship (Type, Print) Peggy R. Thrift (Siste		19b. Mailing Address (Street a 8627 Richmond			City or Town, State re, Maryl	
Ore - F	ury or othe	20a. Method of Disposition 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State	e of Disposition (Name of efery, crematory or other place dens of Faith	1/21		20c. Location - City Baltimore	or Town, State  Maryland
Baltimo	any inju	21. Signature of Funeral Service Licensee Milton	IL.	5305 Harfo	ord Road I	Baltimo	. Ruck, I re, Maryl	
d.		23a. Part1. Enter the disease, or complications that shock, or heart failure. Eat only one cause on	caused the death. I each line.	Do not enter the mode of dyin	g, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
	dician dical niner	Immediate Cause (Finat disease or condition resulting in death)		INFARCTE	) bow	EL		1 DAY
	je je		Due to (or as	s a consequence of):				
68760, ificate be assocuted	physician and the burial-transit and the buri	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		a consequence of):				
W = 1		resulting in death) Last						
deati	hed for	Part II. Other significant conditions contributing to o	feath but not resultin	ng in the underlying cause give	en in Part I.	23b. Dld to	bacco usa contrib	uta to the cause of death?
F.O.	e detach	ENCEPHALITIS (19	41) , +	+YPERTEN	SION	1 🗆 Ya	aa 2□No 3□	Probably 4 Punknown
Division of Vital Records, P.O. Box or or Attending Physician: The law requires that the death central rate death.	cale has been signed by the attending page 2 should be detached for use a Completed by Physician/M					24a. Was ar perform		b. Were autopsy findings available prior to completion of cause of death?
H P	page 2	and the second				1 ☐ Ye	a 200 No	1 Yes 2 No
- Ta	director, pag	25. Was case referred to medical examiner?			26. Place of Death	Check only on	9)	
of Vita Physician:	0 00	1 Yes 200 No Hospital: 1		Outpatient 3□ DOA Other	4 W Nursing Home		nce 6 Other (S	(pecify)
Vision of Attending Por death.	e funera	27. Manner of Death  1 PNatural 5 Pending (Moi 2 Accident investigation	of Injury oth, Day Year)	Ib. Time of linjury 28c. Injury Work	yat k? Yes 2 □ No	d. Describe ho	w injury occurred	
DIVIS	led in by the funeral Certification:	3 Suicide 6 Could not be determined 28e. Plac build	e of Injury - At home ling, etc. (Specify)	, farm, street, factory, office	28	of, Location (Sti City or Town	reet and Number or , State)	Rural Route Number,
Hospital 24 hours	Completely filled in by the funeral Medical Certification: 1	29a. Certifier (Check only one)  (Check only one)	e best of my knowled pasis of examination oner stated.	dge, death occurred at the time and/or investigation, in my op	ne, date and place, an pinion, death occurred	d due to the call at the time, da	use(s) and manner ate and place, and o	as stated. due to the cause(s)
To the	Me	29b. Signature and title of certifler		29c. License	e number	25	d. Date aigned (Me	onth, Day, Year)
F 3 F		In lastus.	n	03	2548	J	annary 1	19 1999
		30. Name and address of person who completed cau  FERRY L COLVIN  31. Date filed (Aproxit) Day Year)	se of death (Item 23	(Type, Print) 6 No	orth Gr	reene	Street	, , , , , , , , , , , , , , , , , , , ,
	State	31. Date med (mornin, Day, Tear)	Registrar's Signature		1	110	14	10
R	egistrar	JAN 2 0 1999 50	was 1	4 land				



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State of Maryland / Department of Health and Mental Hygiene 9 0 6

					Certificate d	of Death	Re	g. No.		
D	_	1. Decedent's Name (First, Middle, La		,			2. Dete of Death Month	Dey	Yeer	3. Time of Dea
Physician /Medical		George R.	DUN	hRM			Junuary	,	1999	4:00 P
Examiner	-	la Facility Name (If not institution, give	street and number)		1	4b. City, Town, or L		4c. County	of Death	- +
		FALISION.	GENEFA	6 14	0301196	FALLS/	on Md	30	81210	Crenty
Funeral	5	5. Social Security Number 6. S	ex 7. Age	(In yrs. last bi	rthday) If Under 1 Ye		8. Date of Birth (Month, Day,	Voerl		lace (Stete or For
Director	6	245 14 7502 !	ØM 20F	78	Yrs. Months De	ys Hours Mill.	12/31	20	S.	C.
2	-	Jaual Residence of Decedent							1	
how a		IOa. State 10b. County		10c. City, Tow	/	100 /			10	0d. Inside City Lie
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th with the Meryler 23e or 28e4 show at be notified at	E 1	10e. Street and Number	4	1.1	10f. Zip Cod		10	g. Citizen of 1		try?
Interdeath with the Meryland reference 28 or 28 or 90 or 100 or 1		3454 ALb	AN TOWN	e wa	M 210	40		4.5	·A	
heme heme		11. Marital Status	12. Wes Decedent E Armed Forces?	ver in U,S.	13. Wes Decedent If Yes, specify (	of Hispanic Origin? (Sp Cuban, Mexicen, Puerto	ecify Yes or No-		ce - Americe ck, White, e	
5-0020 72 hours efter natural", or he see matural or he see matura		1 Never Married 2 Merried	1 ☐ Yes 2 ☑ No If Yes, Give		1  Yes 2		,		BA	- 1
5-0020 72 hours of netural, or		3 Widowed 4 □ Divorced	Year or Detes:		10,00	to opcomy.		Specing		
n 72 hours natural:	ğ	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a	. Decedent's Usuel Oc (Give kind of work do	cupation one during most of work	cina	6b. Kind of B	usiness/Ind	lustry
	<u>a</u> -	Elementary/Secondary (0-12)	College (1-4or 5+	b)		ne during most of work tired) Blads		mel	som,	ck Co
N 355 0	5	12m			226-	BRUND		,,,	~~~~	0,- 0,0
nd 2 selled fother vent, p		17. Father's Name (First, Middle, Last)	<b>~</b>	,			e (First, Middle, N		10)	
Maryland 212 12 should be filed with h end Mental Hyglene. T ie marked other than reumatic event, the		moses	DUNHAN	/		MASSO	35 Coh	CN		
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and 2		ARNITA DUI	VHAM	3	45-4 AL	BANLOWA	IE WAY	Eds	ze Wo	od me
or other tr	2	20a. Method of Disposition		20b. Plece o	d Disposition (Name of	plece)	Date 2	Oc. Location	City or To	wn, Stata
Saltimore emit. Peges 1 Separament of Hi mportant: if Nen ny Injury or oth		1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification )		ask	ulus m	em- VK:	1/23/99	ARbui	tur	mi
Selfim Semit. Peg Separtment mportant: i any injury o		21. Signature of Funeral Service Licen			_22. Neme end Ad		,	001	6	-
E E O O O O O O O O O O O O O O O O O O		Joseph B. 6	Cooks W		7 11	P. 1. O.	F/H 130	24 h.	Cest	Tral a
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Physician /Medical				0	-				1	0
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		,	, ,	Due to (or es a	consequence of):				1	
B # 5			b. Liver	nie ta:	stores.					
68760, lice be executed physician and s the buriel-transit		Sequentially list conditions,								
filtrete be en physician se the burle		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C							
oertificate be refined by the burner of the	3 3	that initiated events resulting in death) Last				1				
E 2 5										
deeth ce et endire ed for use			d							
. 0 . 0	F	Part II. Other significant conditions or	ontributing to death but	t not resulting i	n the underlying cause	given in Pert I.	23b. Did to	bacco vaa co	ntribute to	the cause of de
Phy detection by the true of true of the true of true of the true of true	[	Covoriavez air	ever D 186	eare.			1 🗆 Yı	2 3 No	3 Prot	bebly 4 Unk
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vital Rec sicien: The lew certificate has b lirector, page 2 a		25. Was case referred to medical				26 Place of Dee	th (Check only on	a)		
Physicien: This certificant director,	0	examiner?	Hospital:	t 2 PERVO	utpatient 3 DOA	Other:	oma 5 Reside		ner (Snecih	v)
Phys end d		7. Manner of Death	28a. Dete of Injury (Month, Day			njury at Work?	28d. Describe ho			,
to the the		1 Neturel 5 Pending 2 Accident investigation		Year)		Work? 1 ☐ Yes 2 ☐ No				
DIVISION C be or Attending P as after death. ed in by the funer Certification:	2	3 ☐ Suicide 6 ☐ Could not be	286. Piece of injur	ry - At home, fe	erm, atreet, factory, off	ce	28f. Location (Str	reet end Numi	ber or Rure	I Route Number,
Saga T	5	4 Homicide	building, etc.	(Specify)			City or Town	, Stele)		
	2	29a, Certifier 1/D Certifying Phy	reicien: To the hest of	my knowledou	death occurred at th	e time, date end place,	and due to the ca	use(s) and m	enner es el	ated
he Hospi in 24 hou he Funer pletely fill edical	5	(Check only 2   Medical Exam	iner: On the basis of e	examinetion an	d/or investigation, in n	ny opinion, deeth occur	red et the time, da	ite end plece,	and due to	the cause(s)
DIVISION OF  To the Hospital or Attending Phys Within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral of  Medical Certification: To		29b. Signature and title of certifier	DM-		Q . 29c. Lin	ense number	29	d. Date signe	d (Month	Day, Year)
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	_		1830	O		0 21201		1/1	7"	
	3	0. Name and address of person who				16 mary	Carle De	Rac	OF M	12,21
			ELLA- C		ek! Z'		-21.4	SAF		
State		11. Date filed (Month, Day, Year)	32. Registrar	r's Signeture	1 .	*				
Registrar		IAN 2 0 1990	Sugar	D.	sports	/				

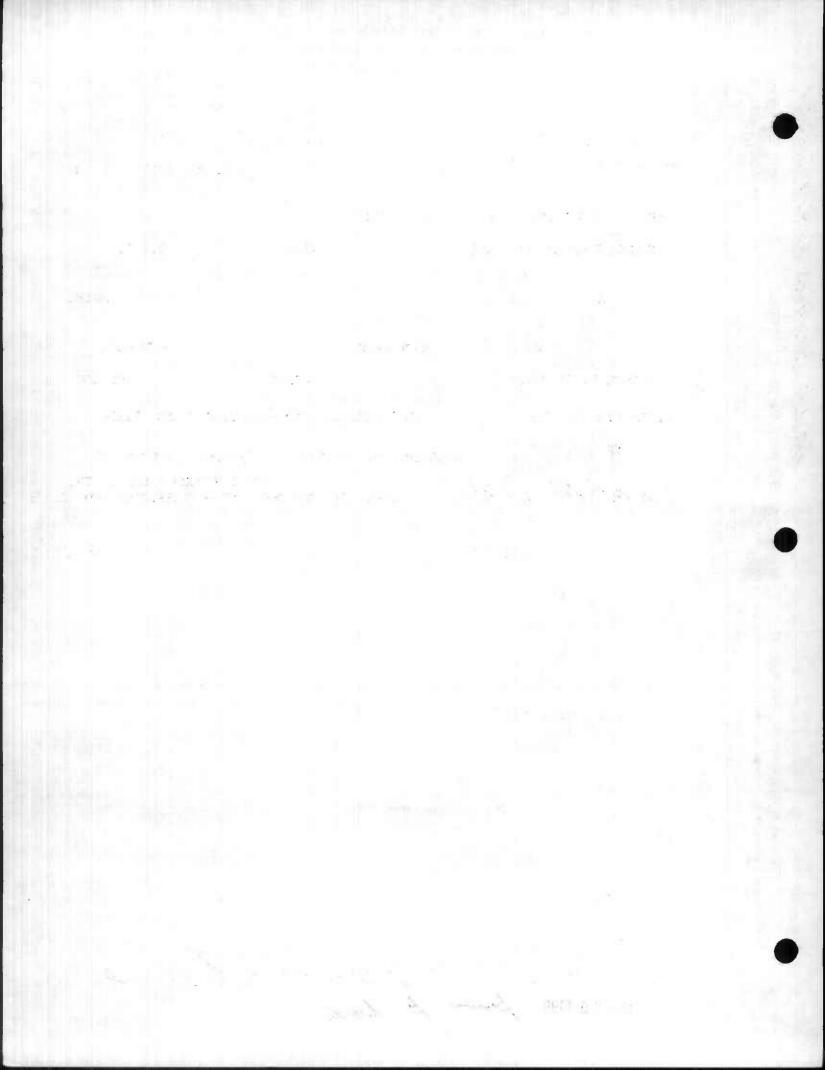


# PATIENT KNOWN AS ALOREY DILLON

DHMH 16 Rav 6/95

		State of M	ar yraire		rtificate		Death			J. No.	U	1911		
a la c	1. Decedent's Neme (First, Middle, L	ast)	7.76						te of Deeth	Dev	Yeer	3. Tima of Dee		
cian Iical	AUDREY			D.	ILLON			Jane	wry,	13 19	799	1:45A1		
er	4e Facility Neme (If not institution, g	ive street and number,	)			4	b. City, Town	, or Location	of Deeth	4c. County	of Death			
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П	5. Social Security Number 6. 219–28–5977	Sex 7. Ag	ge (m yrs. re 67	est birthday) Yrs.		Deys		Min. (M	te of Birth onth, Day, 1	<sup>(ear)</sup> 1931	Count	lece (State or Fo try) MD		
	Usuel Residence of Decedent		- 07					11101	1. 231	1991		LID		
	10e. Stete 10b. County		10c. City	, Town or Lo	cation						10			
	MD BALTIN	MORE		BALTI										
Director	10e. Street and Number  2 CANDLEMAKER (	OURT #101			10f. Zlp 0	Code	21208		10			try?		
בתונומו	11. Marital Status	12. Wes Decedent		S 13	Was Decede	int of H		2 (Specify Y	es or No-					
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•	3 Widowed 4 Divorced	If Yes, Give Yeer or Detes:			1⊡ Yes 2	No No	Specify:		Specify			y: WHITE		
Completed	15. Decedent's (Specify only highest g			16a. Deced	dent's Usuel	Occupa	ation during most of	f working	rorking 16b. Kind of Bu					
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	e? Fakada Nama (Final Middle Ca	~		HOMEM	AKER		10 Mathada	Nome /Fine	Alidella Ali	Bleck, White, etc.  Specify: WHITE  b. Kind of Business/Industry  OWN HOME  iden Sumeme)  DILLON				
0	17. Father's Neme (First, Middle, Last)  MITCHEL S. EISENBERG  HII								, Middle, Mi	siden Sumem		I.ON		
2	19e. Interment's Neme/Reletionship		19b. Malling Address (Street end Number or F											
	BRIAN SIEGEL /		1010 WINDSOR ROAD -									,		
	20e. Method of Disposition		20b. Piece o			e of		Det			on - City or Town, Slete			
	1 ☐ Buriel 2 ☐ Cremetion 3 4 ☐ Donetlon 5 ☐ Other (Spec	Removel from State city)		LTOP S	111-10			1/16	5/99	TOWSC	N. M	D		
	21. Signature of Funeral Service Lic	ensee	. 1		2. Name end					ON & BF				
Examiner	temediate Cause (Finel disease or condition resulting in deeth)  Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	a. Sepsis		r es e consec								2 days		
lical	Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of):													
	resulting in deetil) East	d												
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	Pert II. Other significant conditions		but not resu	ulting In the u	nderiying ca	use giv	en in Pert I.		1 Va	a 2 No	3 Prot	pebly Unk are eutopsy findin hilable prior to impletion of cause deeth?		
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Completed by Physician/Med	25. Wes case referred to medical exeminer?  1 Yes 2 No  27. Menner of Deeth 1 Natural investigat 3 Suicide 6 Could not determine  29e. Certifier (Check only one)	Hospitel: 1 Inpati 28e. Dete of Inj (Month, Di de 28e. Plece of In- building, e	ient 2 0 innury ey Year)  injury - At honoric. (Specify)  of my known to exeminettated.	ER/Outpetier 28b. Time or Injury ome, farm, str ome, farm, str ome, farm, str ome, farm, str ome, farm, str ome, farm, str	nt 3 DO/f 28 M reet, fectory, h occurred e vestigetion, 29c.	A Oth  A Oth  Wor  Office  It the tin my o	26. Place of er: 4 \( \to \) Nursi y et k? Yes 2 \( \to \) No	28d. Do 28f. Lc	1 Yes  4e. Wes an perform  1 Yes  5 Resider  6 Resider  6 rescribe how  cocation (String or Town,  ile to the called time, del	eutopsy ed?  2 No  oce 6 Oth vinjury occur  oet and Numb  sets and me te and place,	3 Protestant Section 1 Protest	bebly Unk  are eutopsy findir aliable prior to mpletion of cause deeth?  Yes 2 No  No  Route Number, lated. the cause(s)		

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3:40 PW ALBERT DEINER JANUARY 14, 4b. City, Town, or Location of Deeth 4e Facility Neme (If not Institution, give street and number) 4c. County of Death Hospital Center Northwest RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1XM 2□ F 70 Yrs 131-20-9313 SEPT.16,1928 Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 6402 ELRAY DRIVE 21209 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Reca - American Indien, Black, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry **GROUNDS** Elementary/Secondary (0-12) College (1-4or 5+) CHEMIST SENIOR RESEARCH ABERDEEN PROVING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DEINER BENJAMIN BESSIE SCHWEITZER 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY DEINER / WIFE 6402 ELRAY DRIVE #B - BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Buriel 2 ☐ Cremetion 3 ☐ Removal from State 1/17/99 ARLINGTON CHIZUK AMUNO BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Tolerto 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. pere Shock Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the ceuse of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to 24a. Was an eutopsy completion of cause of death? M.T. 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Inpatient 1 Yes 2 No 2 ER/Outpetient 3 DOA

**Physician** /Medical Examiner

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medicai

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

Be

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner rount be notified at

filed within 72 hours after death with the Maryland

Hygiane.

and Mental

permit. Pages 1 and 2 should be Department of Health and Mental Important: If frem 27 is marked cany injury or other traumatic even page.

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altimore, Maryland 21215-0020

The law requires that the death certificate be axe ed by the detached signed i s certificata has t or Attending Physician: Aftar thi funeral the Funeral Director: Aft

Division of Vital Records, P.O. Box 68760,

25. Wes case referred to medicel examiner?

2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifier (Check only one)

14 cute

27. Manner of Death 1 DiNatural 5 Pending investigation 6 Could not be datarmined

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury et Work? 1 Yes 2 No

28t. Location (Street and Number or Rural Route Number, City or Town, State) Codifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated Discoursed at the time, determiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, determined and place, and due to the Eal Examinar: On the basis of exeminetion and/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

28d. Describe how Injury occurred

nu)

29c. License number D44505

NWHE

29d. Dete signed (Month, Day, Year) JANUARY W. 1999

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

I VIMPERIAL, JR, MD

31. Date filed (Month, Day, Year) JAN 2 0 1999 32. Registrar's Signature

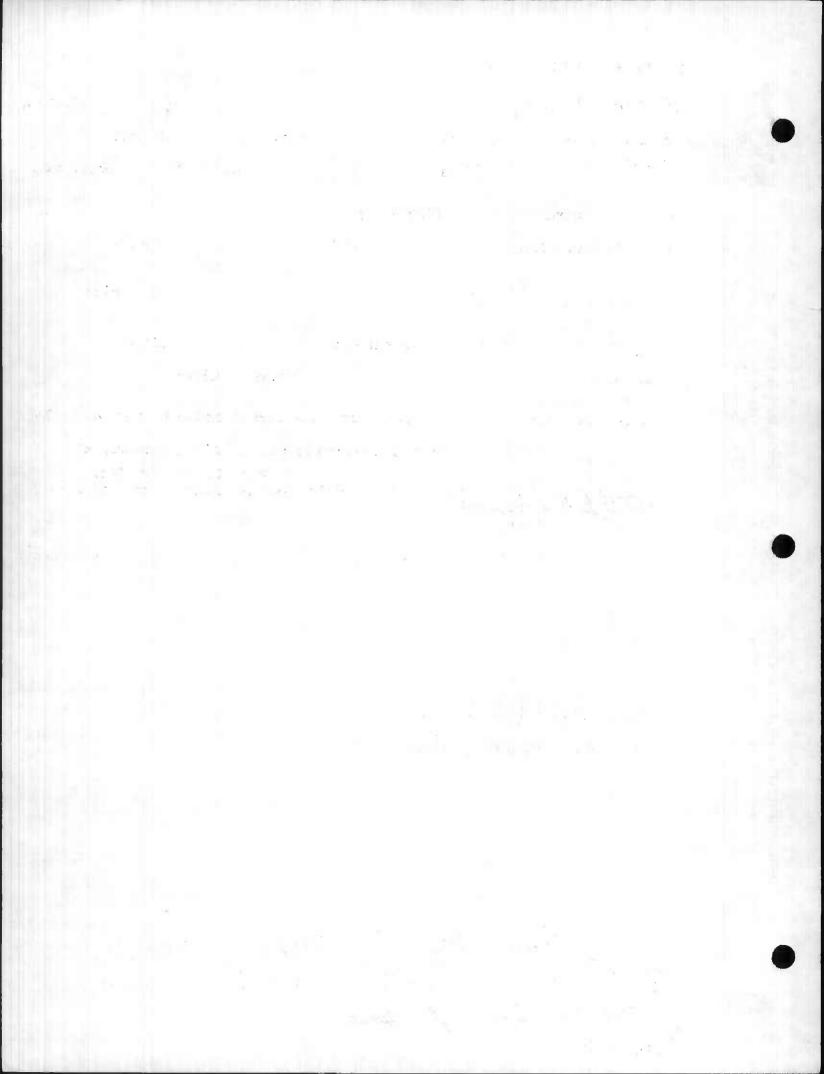
G. Sparket

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Item:7per F.H G-767 1/28/99 reb Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 1:30 AM IRENE DAILE 1999 JAN 16 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Sykesville Carroll Continuum Care of Sykesville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day Year) 5. Sociel Security Number 216-07-8062 9. Birthplece (State or Foreign **Funeral** Months Deys Hours 1□M 20 F Pennsylvania 83 Director Usuel Rasidance of Dacedani the Maryland 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 7 is marked other than "natural", or hams 23s or 28s-f show traumatic event, the Modical Experience must be notified at Carroll Eldersburg 1 Tyes 2 No MD Directo 10e. Streef and Number 10f. Zip Code 21784 10g. Citizen of What Country? with 1413 Woodridge Lane Funeral death 12. Wes Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ∑XNo If Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien 11. Merifel Stetus Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after of an and of health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or that uny or other traumatic evant, the Mental Experient uny or other traumatic evant, the Mental Experient. 1 Never Married 2 Married Specify: White altimore, Maryland 21215-0020 1 Yes 2 X No Specify: by 3 DWidowed 4 Divorcad Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Dacadant's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) Office Receptionist 17. Fether's Neme (First, Middle, Last)
John Wingo 18. Mother's Neme (First, Middle, Maiden Sumeme) Helena Kuhnert Be 19a. Informent's Neme/Raiationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Coda) Maryland 21784 Woodridge Lane Eldersburg, Carolyn Rawleigh 20b. Place of Disposition (Neme of 20e. Method of Disposition Date 20c. Location - City or Town, State Inmanuel Lutheran Cemet. 1 Burial 2 ☐ Cremation 3 ☐ Removel from Stete 1/19/99 Baltimore, MD permit. Page Department of Important: If any Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility John C. Miller 21. Signeture of Funeral Servica Licensee 6415 Belair Road Baltimore, Maryland 21206 23a. Pert1. Entér le disease, or complicator shock, or heart feilure. List only one can That ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, non each ling. Approximete Intervei Between Onset end Deeth **Physician** lumonia Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Dua to (or as e consaguenca of) Examiner attending physician and for use as the burial-transit requires that the death certificata be axecuted Sequentially list conditions, if eny, leading to immadiata causa. Entar Underlying Causa (Disaase or injury that initiated avants resulting in death) Lest Due to (or es e consequence of) Box 68760. Physiclan/Medical Due to (or es e consequance of): P.O. 23b. Did tobacco use contribute to the ceuse of death? Part ii. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Part i. 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records. by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes an eutopsy performed? Completed paga 2 certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: filled in by the funeral director Be 25. Wes case referred to medical 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No To After this 28e. Date of injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Natural 5 Panding investigation after death. 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 6 Could not be datamined 3 Suicide 28a. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicida 24 hours 1 Cortifying Physician: To the bast of my knowladga, daeth occurred et tha tima, date end pleca, end due to tha causa(s) and mannar as statad.
2 Medicat Examiner: On the basis of examinetion end/or invastigation, in my opinion, daath occurred et the time, dete end plece, and dua to tha cause(s) end menner steted. 29a. Cartifiar edicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Deta signed (Month, Day, Year) 29b. Signetura end titla of certifier 30. Name and address of person who completed cause of deeth (Itam 23a) (Type, Print) ( Kushne Jonathan 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State JAN 2 0 1999 Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Robert L. Elburn 01:40 AM JANUARY 4b. City, Town, or Location of Death 19 1999 4c. County of Death 4a Facility Name (If not institution, give street end number) GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) Days 100 M 2□ F Months Hours August 31,1935 Maryland 213-32-3032 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits Y Yes 2□No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 2623 Miles Avenue USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Merital Status 1 ☐ Never Married 2 K Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Stationary Engineer Facility Maintainence 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Burton Elburn Gertrude Piechaioki 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Elburn (Wife) 2623 Miles Avenue, Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Woodlawn Cemetery 1/22/1999 Woodlawn, Maryland 21. Signature of Franeral Service License 22. Name end Address of Facility Burgee-Henss Funeral Home, PA 21211 23a. Part. Enter/the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth RESPIRATORY FAILURE Immediate Cause (Final diseese or condition resulting in death) SEPT CEMIA Due to (or as a consequenca of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last METASTATIC GASTRIC CANCER Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco was contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown HYPERCALCEMIA OF MALIGNANCY 24a. Was an autopsy performed?

**Physician** /Medical Examine

**Physician** 

/Medical

Examiner

Directo

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Be

**Funeral** 

Director

**Physician/Medicai** þ Be Certification: After or Attending s after death.

I Director: After the function of the function

Division of Vital Records, P.O. Box 68760

C.O.

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menger of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 1 Yes 2 No

1 Natural 2 Accident 5 Pending investigation 6 ☐ Could not be 3 ☐ Suicide 4 | Homicide

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

29a. Certifier

29c. License number

29d. Date signed (Month, Dey, Year)

Recymond A Nizem PA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

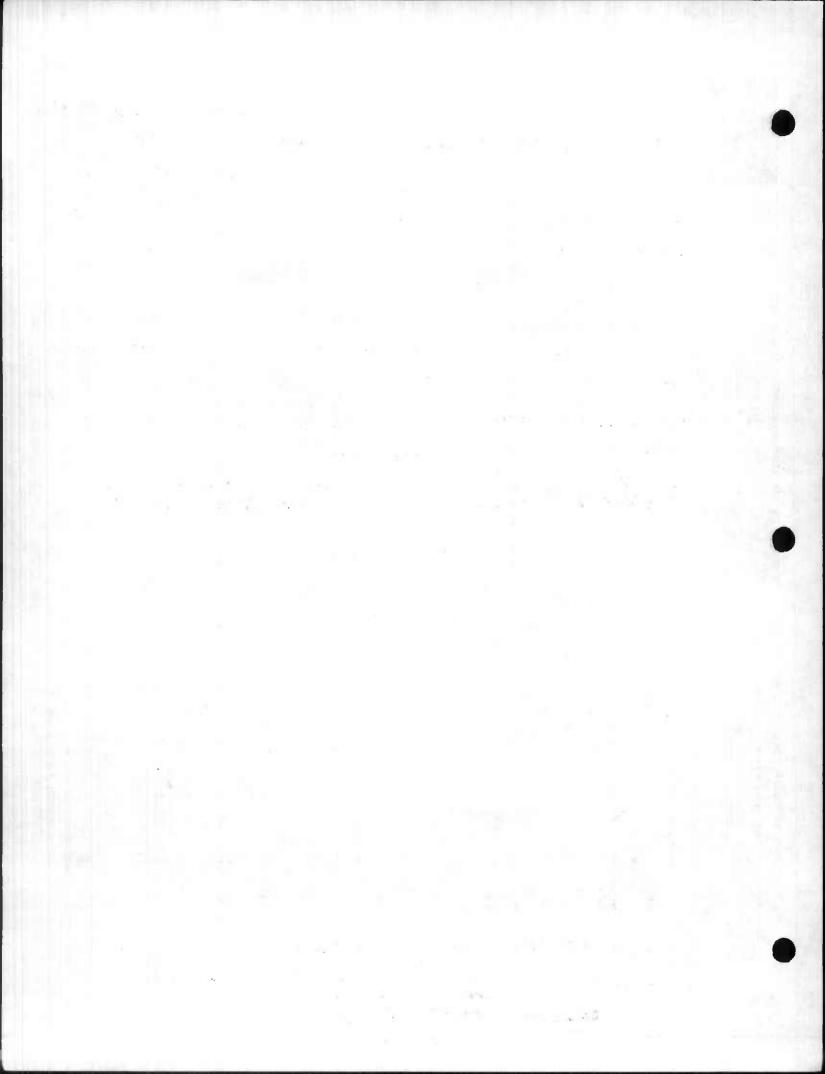
RAYMOIND A-NZE MD PA 7801 YURK RD #100 TOWSON MD 2120 Y 31. Date filed (Month, Day, Year)

Registrar

edical

32. Registr I's Signature

To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth Month ANWARY

1. Decedent's Neme (First, Middle, Last) **Physician** Lloyd Enders /Medical 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Arundel Glen Burnie North Arundel Hospital If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) 6. Sex **Funeral** Deys ₩ 2 F Months Hours 188-20-5277 70 Yrs. Director May 19, 1928 Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location d 2 should be filed within 72 hours efter death with the Marylan th end Mental Hygiene.
7 Is merked other than "naturel", or items 23s or 28s-f show trennstic event, the Medical Examples must be notified at Maryland Anne Arundel Glen Burnie Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7355 Furnace Branch Road 21061 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? unknown Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumame) Be Pages 1 end 2 should be nent of Health end Mental unknown unknown 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) permit. Pages 1 end 2: Department of Health er Important: if fem 27 is. any Injury or other treu once. unknown 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 ☑ Other (Specify) in state 21. Signeture of Funeral Service Licensee Ronald S. Wade 32 Name end Address of Facility Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. **Physician** Immediete Ceuse (Final diseese or condition resulting in deeth) /Medical (EPSB Examiner Due to (or es e consequenca of): PICA Examiner PNEUMONIA physician end the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieled events resulting In death) Lest Due to (or es a consequenca of). Physician/Medical Due to (or es e consequence of): 88 for use as 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown

The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760 ed by the a signed by t þ been sig Completed hes certificate or Attending Physician: Be 10 this After thi Certification: hin 24 hours after deeth.

the Funeral Director: Af
mpletely filled in by the fu deeth.

> State Registrar

edical

29a. Certifier (Check only one)

24b. Were autopsy findings aveilable prior to 24e. Wes an eutopsy performed? completion of cause of deeth? 200 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 1 Monationt 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier

29c. License number

29d. Dete signed (Month, Day, Year)

MD 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

3. Time of Death

Birthplece (State or Foreign Country)

10d. Inside City Limits

Approximete Intervel Between Onset end Death

1 ☐ Yes 2 ☐ No

Maryland

White

11:00 Am

301/02/102 MUENN olen

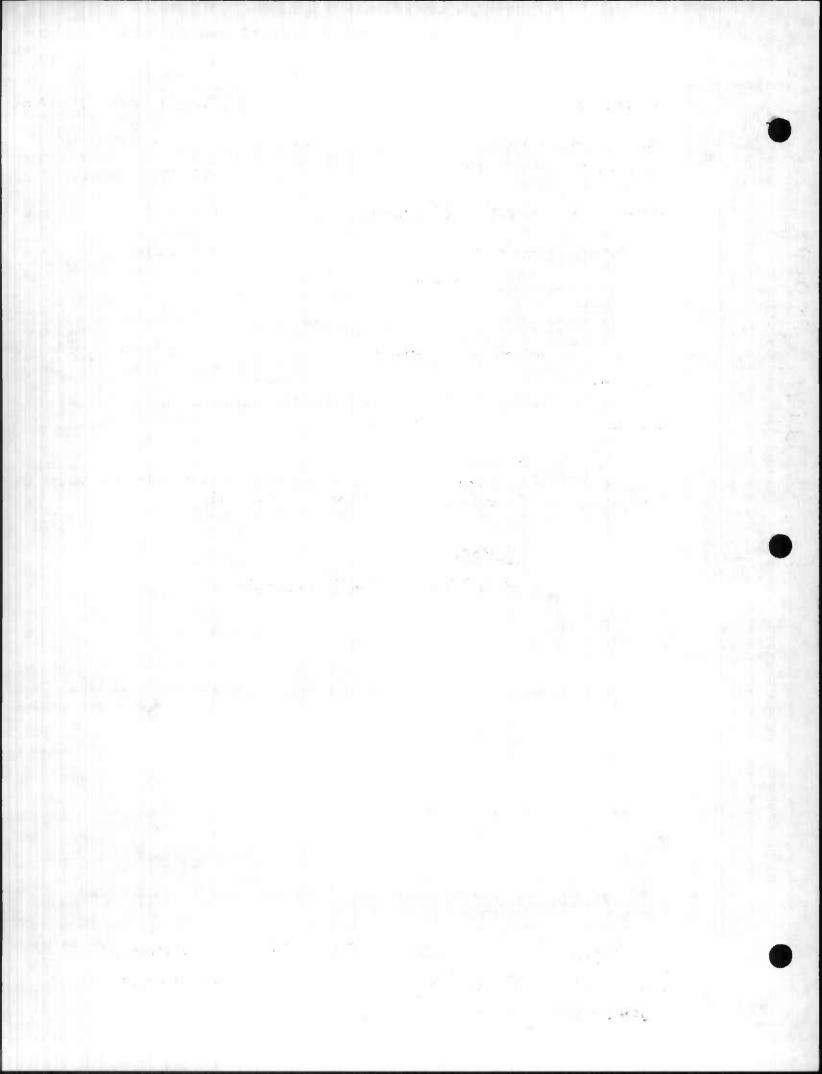
E, GLEW BURNIE, mp. 2061.

37. Dete filed (Month, Dey, Year) 32. Registrer's Signetur JAN 2 0 1999

Hospital

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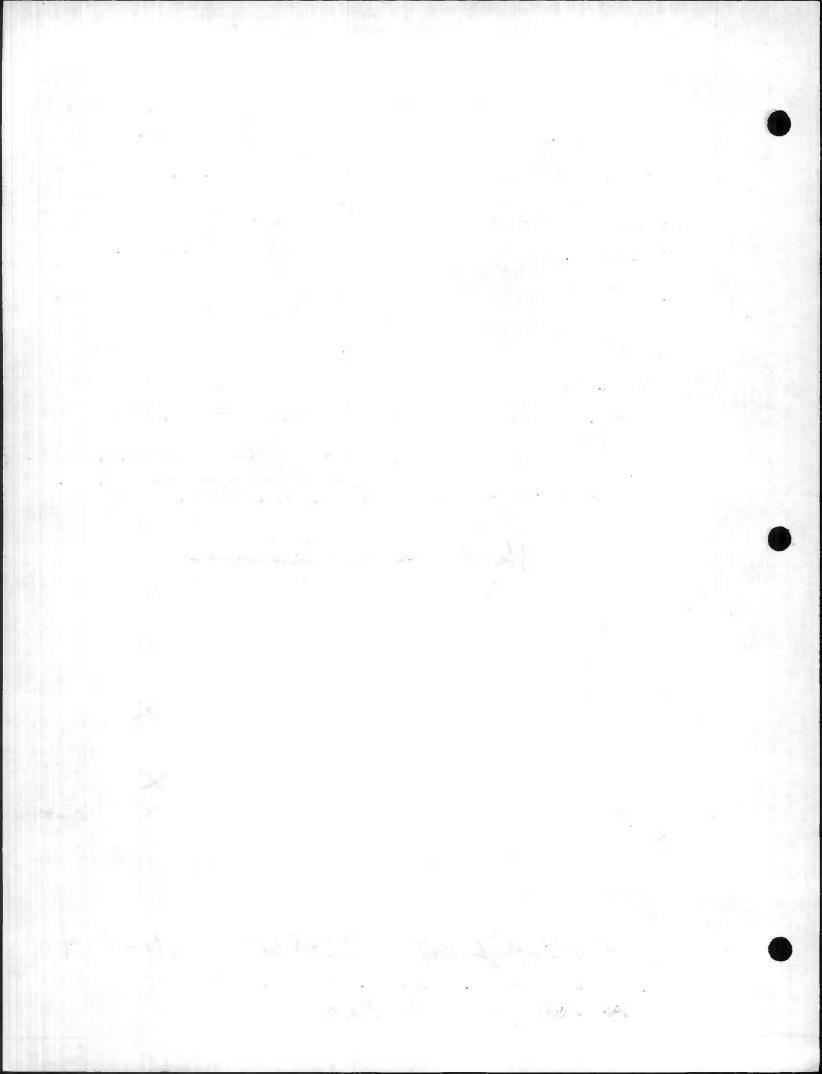


### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Yaai **Physician** Fisher Virginia Christine January 13,1999 6:05AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9458 Belhall Drive Perry Hall Baltimore If Undar 1 Yaar Birthplaca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) **Funeral** Days Months Min. Hours 1 □ M 2 1 F Yrs Director Sept. 25,1916 Maryland 216-54-3637 82 Usual Rasidance of Decedant 10a Stata 10b. Counts 10c. City. Town or Location 10d. Inside City Limits the Maryla r than "natural", or Nerre 23s or 28e-f shorthe Medical Examiner must be notified at 1 ☐ Yes XIX No Directo Colgate Maryland Baltimore 10g, Citizan of What Country? 10e. Street and Number 10f. Zip Code 21224 United States 716 North Pt. Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 12. Wes Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva 1 ☐ Navar Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify. à White 3 M Widowed 4 □ Divorced Yeer or Detes: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiens. Elamentary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 Years 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Be L. Pages 1 and 2 should be trained of Health and Mertal tant: If Ilam 27 is marked or Christine (Not Known) Julius E. Akerstrom 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Linwood A. Fisher/Son 9458 Belhall Drive Perry Hall, Maryland 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, Stete Buriel 2 Cramation 3 Ramoval from Stata 8 Oak Lawn Cemetery 1/15/1999 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disaese, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Batween Onset and Death Physician /Medical Immediate Causa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as e consequence of): Examiner physician and s the burial-transit Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Causa (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequenca ot): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence ot): attending p ed by the a Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 3 Probably 4 Unknown 1 Yes 24) p 24b. Were eutopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of deeth? certificata 1 Yas 1 Yas 2 No funeral director, 25. Was casa raterred to medical Be 26. Placa of Death (Check only ona) examiner' Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Son's Home 1 Yas 2 No 70 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural 2 Accident death. 1 Yas 2 No after death Director: / 6 Could not be datarmined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, straet, factory, office building, atc. (Specify) 4 Homicide Hospital 24 hours a Funeral D 29a. Certifier Scertifying Physician: To the best of my knowledgs, death occurred at tha time, data and plece, and due to the cause(s) end menner as stated. To the Hosp within 24 hor To the Fune completely fi Medical 2 | Medical Examiner: On the basis of axaminetion and/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) and mannar stated. mid tittle of certifian 29c. Licensa number 29d. Date signed (Month, Day, Year) a of daeth (Item 23a) (Type, Print) 30. Nama and address of person who complated ca Baltimore, Maryland 21224 East Pt. Medical Ctr. Dr. Paul Valley 31. Data tiled (Month, Day, Year)

**DHMH 16 Rav 6/95** 

State Registrar 32 Registrar's Signatura



Funer

Directo

permit. Pages 1 and 2 should be fled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or hams 23s or 28s-f show any injury or other treumstic event, the Medical Examinal must be notified at

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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State of Maryland / Departmen	t of	He	ealth	and	Ment	al H	lygien	e9	(
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Director	Maryland	N/A		100.	Baltim											
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-	19e. Informant's Name/Relation	19b. Mei	iling Addre	ss (Street					n, State. Zio	Code)						
	Karen Funk			)		_		rn Ave								
	20a. Method of Disposition			20b	. Place of Disp	osition (N	ame of		-1140	T						
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	21. Signature of Funerel Servi	ce Licanse	e Micho	ما ٦ ٥	Daklawn			ss of Facility		/19/99	Bait	ımore	, Maryla			
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	Leonard J. Ruck, Inc. Baltimore, MD 21214															
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** Mary Regina Fritzges January 14, 1999 12:05 PM /Medical 4e Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Eldercare- Hamilton Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
Aug. 18, 1896 7. Age (In yrs. last birthday) If Under 1 Yaar 9. Birthplece (State or Foreign **Funeral** Months Days 1 M 2 K F 102 Yrs. Maryland Director 220-48-8208 Usual Residence of Decedan 10a. Steta 10b. County 10c. City. Town or Location 10d. Insida City Limits 28a-f show 1 XYas 2 No Director Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b must be "natural", or flams 23a 2903 Shirey Avenue 21214 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2\( \) No If Yes, Give Year or Dates: 14. Reca - Amarican Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried Specify: White Baltimore, Maryland 21215-0020 1 Ves X No Specific à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b Kind of Business/Industry Hyglene. Elementary/Secondery (0-12) College (1-4or 5+) 8 Homemaker Own Home permit. Pages 1 and 2 should be the Department of Health and Mental Hy important: if Nem 27 is merited other any Injury or other \*\*\* 17. Father's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Surneme) Be James O'Keefe Mabel unknown 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. John H. Fritzges / Son 2903 Shirey Avenue Baltimore, MD 21214 20e. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State ₩ Burial 2 Cremetion 3 Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 1/19/99 Baltimore, Maryland New Cathedral Cemetery Timothy Harman 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. Funeral Baltimore, Maryland 21214 5305 Harford Road 23a. Pert1. Entar the disasse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Deeth **Physician** /Medical Immediata Cause (Finel disaasa or condition resulting in death) Examiner Due to (or es e consequence of) Examine tensus physician and the buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Lest to (or as a consequence of): Heent Box 68760. Sc Physician/Medical Due to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 94 signed by t 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were eutopsy findings aveilable prior to completion of causa of death? 24a. Was en eutopsy performed? Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case raferred to medical exeminer? Be 26. Place of Death (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t
completely filled in by the funera or Attending 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the best of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Cartifier (Check only one) 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) January 14, 1999 SWE

Registrar

State

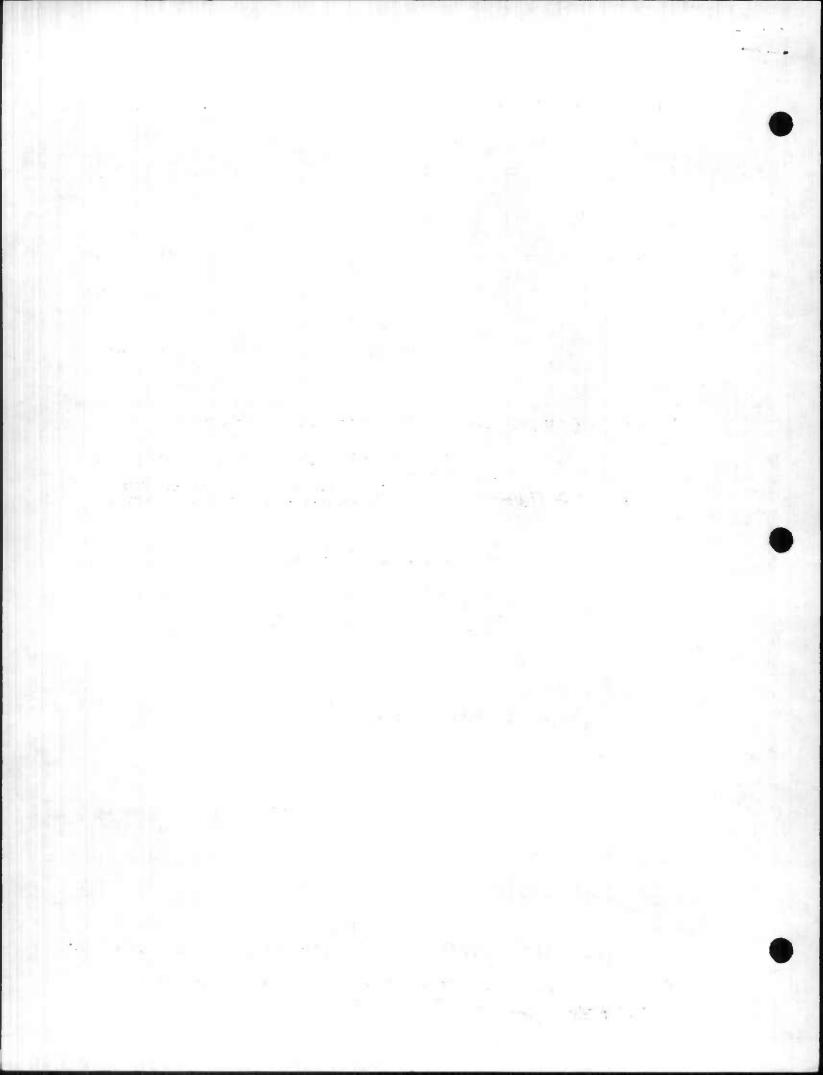
9618 Belair Road Baltimore, Maryland 21236

30. Name and eddress of person who completed causa of death (Item 23a) (Type, Print)

32. Registrar's Signature

Howard Bond, M.D.

31. Date filed (Month, Day, Year) 1 9 1999



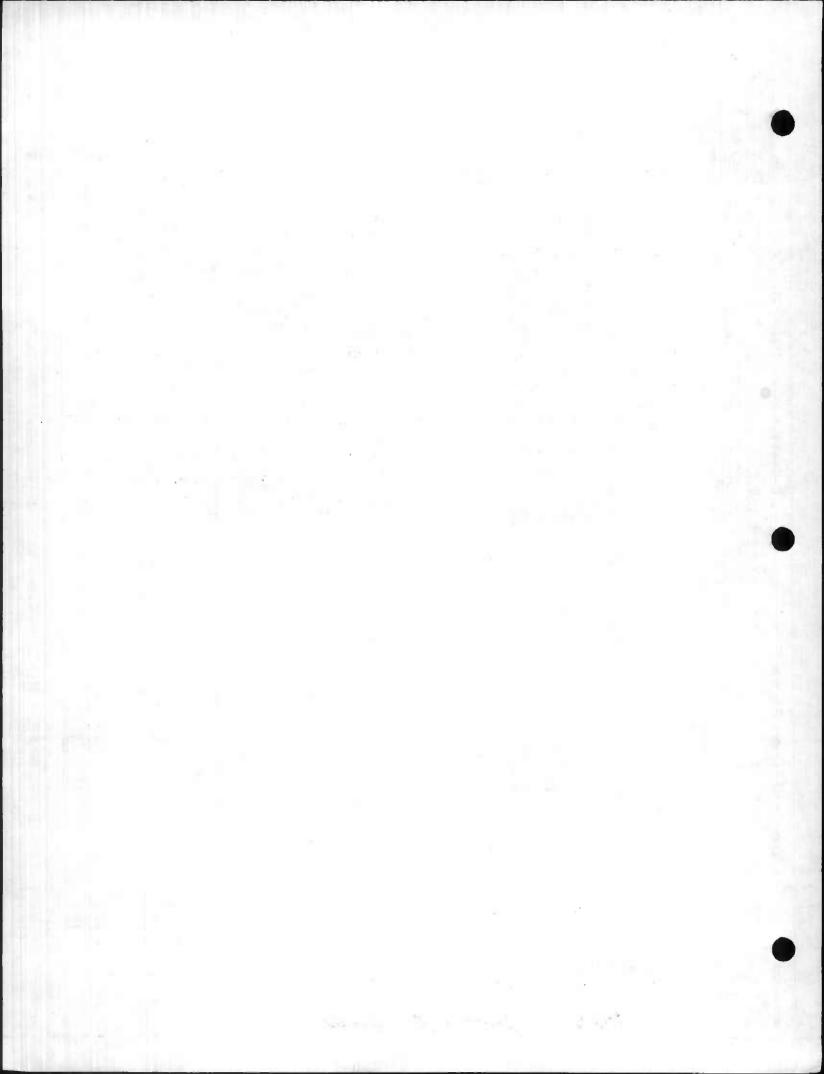
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State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical	Earl Tyrone	Gibbs				JANUAR	Y 15	1999	6:40	A
Examiner	4a Facility Name (If not institution, give				•	Location of Death	4c. County	of Death		
	JOHNS HOPKINS	HOSPITAL			BALTIMO		NA	4		
Funeral Director		7. Age (In yrs. 45	· last birthday) Yrs.	Months Days				9. Birthple Countr MD	ice (State or y)	Foreign
2	Usuel Residence of Decedent  10a. State 10b. County	10c Ci	ity, Town or Loc	ation				10	d. Inside City	v I imits
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vith the Ma t or 28a-t s be notified Director	MD NA		Daitimo	10f. Zip Code		10	Og. Citizen of W	That Countr	20.00	
ath with 22s or nut be.	750 Richwood A			2121			USA			
d within 72 hours after death with the Maryta gene in their heatural, or thems 23e or 28e-f show the Medical Examiner must be notified at completed by Funeral Director	11. Maritel Status  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:		Ves, specify Cul  Yes 2 No		Specify Yes or No- rto Rican, etc.)	Blac	JSA  14. Race - American Indian, Black, White, etc.  Specify: Black ind of Business/Industry  Ver-Worked  Sumame)  Send  v Town, State, Zip Code)		
72 hz	15. Decedent's Edu (Specify only highest gred	ucation de completed)	16a. Decede	ent's Usual Occu	pation during most of w	orkina	16b. Kind of Bu	siness/Indu	istry	
ed within 72 ho typiens. wer than "naturn it, the Medical E Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of w ed)					
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To To	Earl Wilson J		1 461 11		Peggy		wnsend		2-4-1	
12 sh h and lis m traum	19a. Informant's Neme/Relationship (T) Patricia Town									2121
	20a. Method of Disposition		Place of Dispos		ou avein					2121
semit. Pages 1 a bepartment of Hea mportant: if Item iny Injury or othe shift.	1 Surial 2 Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Removal Irom State	cemetery, crem	etory or other placem. Pk.		1-21-99			stown	, MD
permit Depart Import any in	21. Signature of Funeral Service Licens	المحالية المحالية		Name and Addr		Baltimor		-		202
	23e. Pert1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the dea							Approximate	
ficate be required physician and s the burial-transit edical Examiner	resulting in death)  Sequentially list conditions, if eny, leading to immediate		1							
\$ 014 E	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	c Due to (d	or as e consequ	ence of):						
the death certy the attending sched for use						1				
P 25 C	Part II. Other algnificant conditions co	ntributing to death but not res	sulting in the un	derlying cause g	iven in Part I.	23b. Did to	becco use cor se 257No		the cause of ably 4□L	
v requir						24a. Was a perform		eva	re autopsy fi ilable prior to apletion of ca eath?	
The law sate has be page 2 s						1 PY	s 2 No	159	Yes 2□i	No
or Attending Physician: The law after death.  Director: After this certificate has d in by the funeral director, page 2 ertification: To Be Comp	25. Was case referred to medical examiner?					eath (Check only on	θ)			
Physician: this certific ral director.	1 No 2 No		ER/Outpatient	3LI DUA		Home 5 ☐ Reside			)	
ding Pl After ti funera	27. Manner of Death 1 □ Neturel 5 □ Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time of injury	28c. Inju		28d. Describe ho	w injury occurr	ber		
Attending or death. ector: After by the fune	2 Accident Investigation 3 Suicide 6 Could not be	1-15-99	1000	'.	Yes 2 PNo	545,0	W 51	70-	Donate M.	
to a stending P as a stending P as a forector. After ted in by the funers Certification:	4 Phomicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	et, fectory, office		28f. Location (St City or Town 2327	, State)	er or Rural	Route Numb	
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp		ner: On the basis of examination and practice stated.								
To the vithing to the comp	29b. Signature and title of certilier	08/1		100000000000000000000000000000000000000	nse number		9d. Date signed	100		
2	1	14		0.C.	M.E		JANUARY	15,	1999	
3	30. Name end address of person who co	ompleted cause of death (Ite	m 23a) (Type, P	'rint) 111 Pen	n Street	, Baltimo	re, Mar	yland	2120	1
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	eture							
State Registrar	18N 9 A 100	// /	4	1						

DHMH 16 Rav 6/95

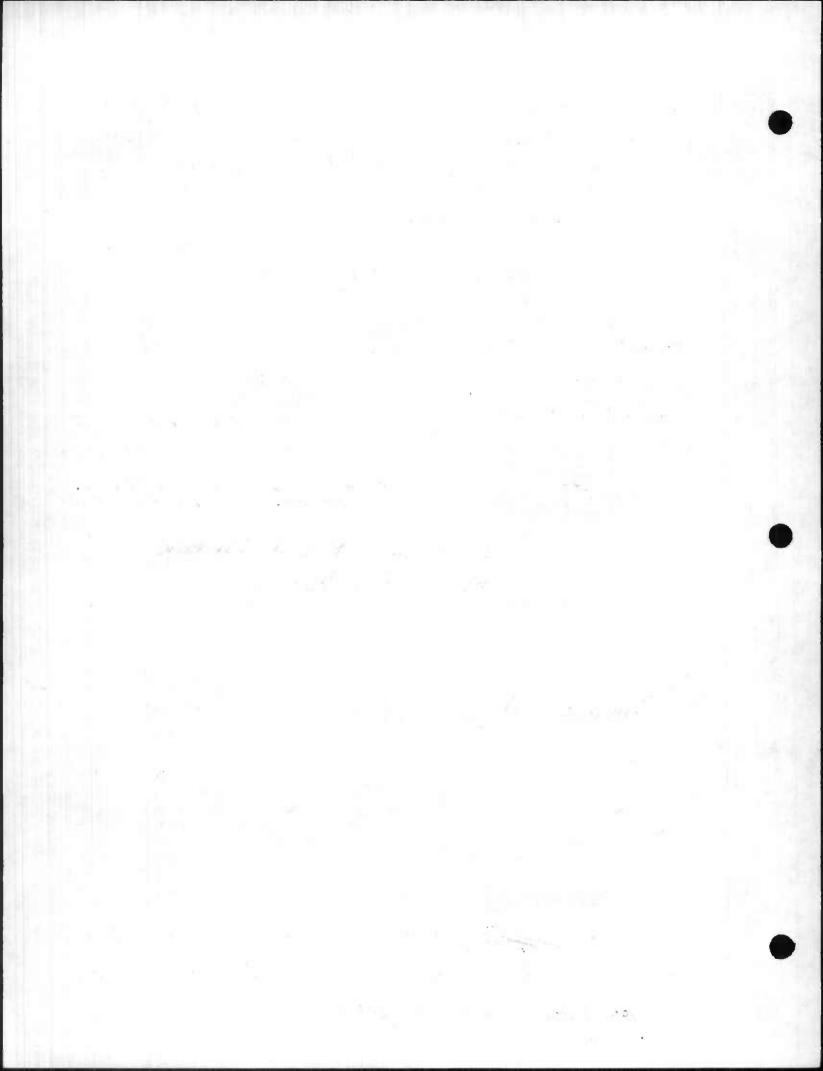
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State of Maryland / Department of Health and Mental Hygiene 9 9 0 9 2 6

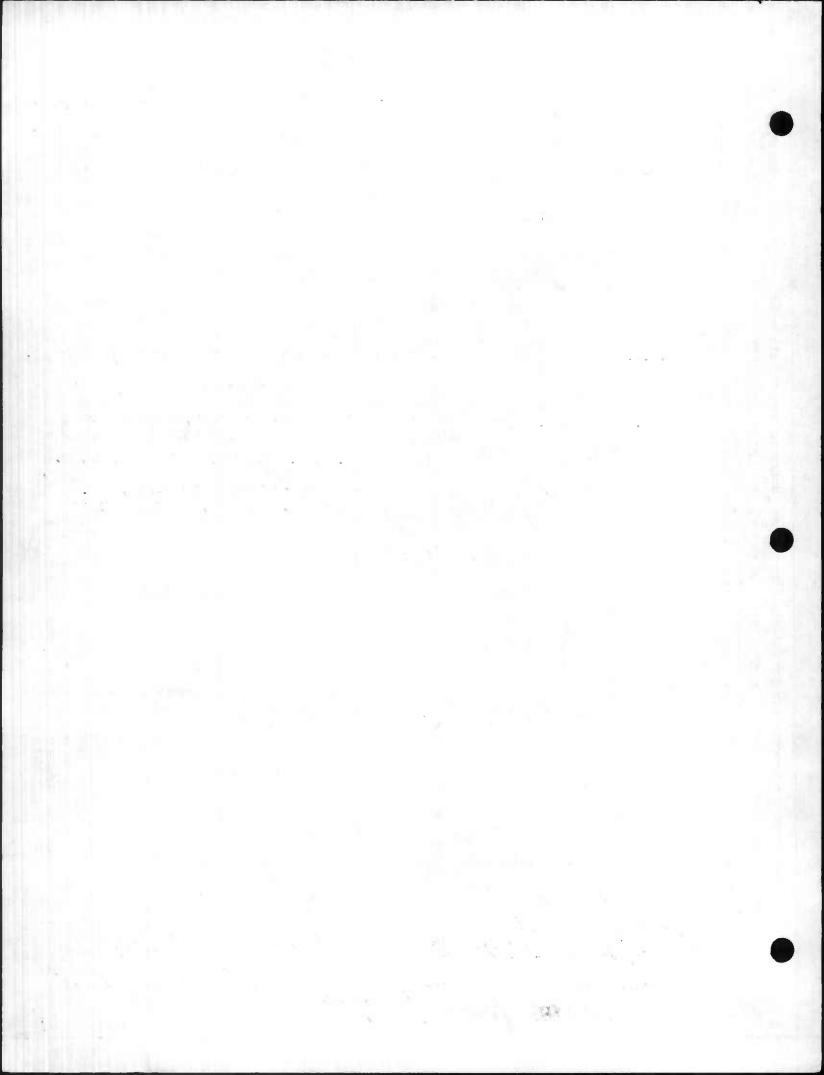
Discontinu	Decedent's Name (First, Middle, La.	st)					2. Date of Dea Month	th Day	Year	3. Tima of Death		
Physician /Medical	Mary Keesee Gosho						lanuary	13,	1999	3:30 am		
Examiner	4a Facility Name (If not institution, give	re street and number)					ation of Death	4c. Count				
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Funeral l Pirector		M 2 X F	(In yrs. last birt		Days Hours	Min.	8. Date of Birth (Month, Day 11-21-1	903	9. Birthp Coun Virg	laca (State or Foreignty) inia		
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or 28 Se no	10e. Street and Number			10f. Zip Co				0g. Citizen of				
ral lan	1924 Ewald Ave.			2122				United				
bi, or items 23e or 25e-fe Examiner must be notified by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yas, Giva Year or Dates:		13. Was Deceden If Yes, specify  1 Yes 20		gin? (Spec i, Puerto R	city Yes of No- lican, etc.)					
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27 is	Juanita K. Baker			816 Highp			altimor					
e di	20a. Method of Disposition	In	20b. Place of	Disposition (Name y, crematory or other	of		Date	20c. Location	_			
ury or	Donation 5 ☐ Other (Specify		1	awn Cemet	C - 11 P. 15	5/199	9	Balti	more,	Maryland		
odul eny i	23a. Part1. Enter tha disaase, or compshock, or heart failure. List only		the death. Do n	Duda-R	Address of Facilit Luck Fund Lise Ave of dying, such as	eral	ndalk.	Maryla		nc. 1222 Approximate Interval Between		
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State of Maryland / Department of Health and Mental Hygiene 9 0

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Richard Month M. Gaydos **Physician** 15, 1999 January 12:08 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3222 Wallford Drive Dundalk Baltimore 5. Social Security Number If Under 1 Yaar 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XXM 2DF Months Days Hours Yrs. Director 218-28-7952 65 March 25,1933 Maryland Usual Residence of Decedent the Maryland 10a State 10b Counts 10c. City. Town or Location 10d. Inside City Limits tam 27 is marked other then "natural", or fems 23s or 28s-f show other traumatic avent, the Medical Executar must be notified at Dundalk 1 Yes 2€ No Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 3222 Wallford Drive Funeral death 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after of Hygiene.
Other then "natural", or Ital 1 Nas 2 No If Yas, Giva Year or Dates: Korean 1 ☐ Never Married 2 Namied Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Western Electric Co. G.E.D. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flam 27 is marked other any linjury or other traumatic avent. Pagis. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hannah Sequi John Gaydos 19a. Informant's Name/Ralationship (Type, Print) Wife 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3222 Wallford Drive Dundalk, Maryland 21222 Mrs. Patricia A. Gaydos 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem. Gdns. 1/18/1999 4 ☐ Donation 5 ☐ Other (Specify) Middle River, MD 21. Signature of Pytheral Service Light 22. Nama and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and s the burial-tranait the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequence of) 50 for usa as 188 ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown KIL signed b Records, þ The law requires 24b. Were autopsy lindings available prior to completion of cause of death? should I 24a. Was an autopsy performed? Completed page 2 s 1 Yes 20 No 1 Yes 20 No of Vital 25. Was casa refarred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Desidence 6 Other (Specify) 1 Yas 20 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Division Attending 5 Pending invastigation death. 1 Yas 2 No 2 Accident Director: / 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide in 24 hour. the Funeral Direction hours after 6 Hospital 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 3 140 U2250 1012 000 31. Data filed (Month, Day, Year) 32. Pagistrer's Signatura sporks. State JAN 19 Registrar



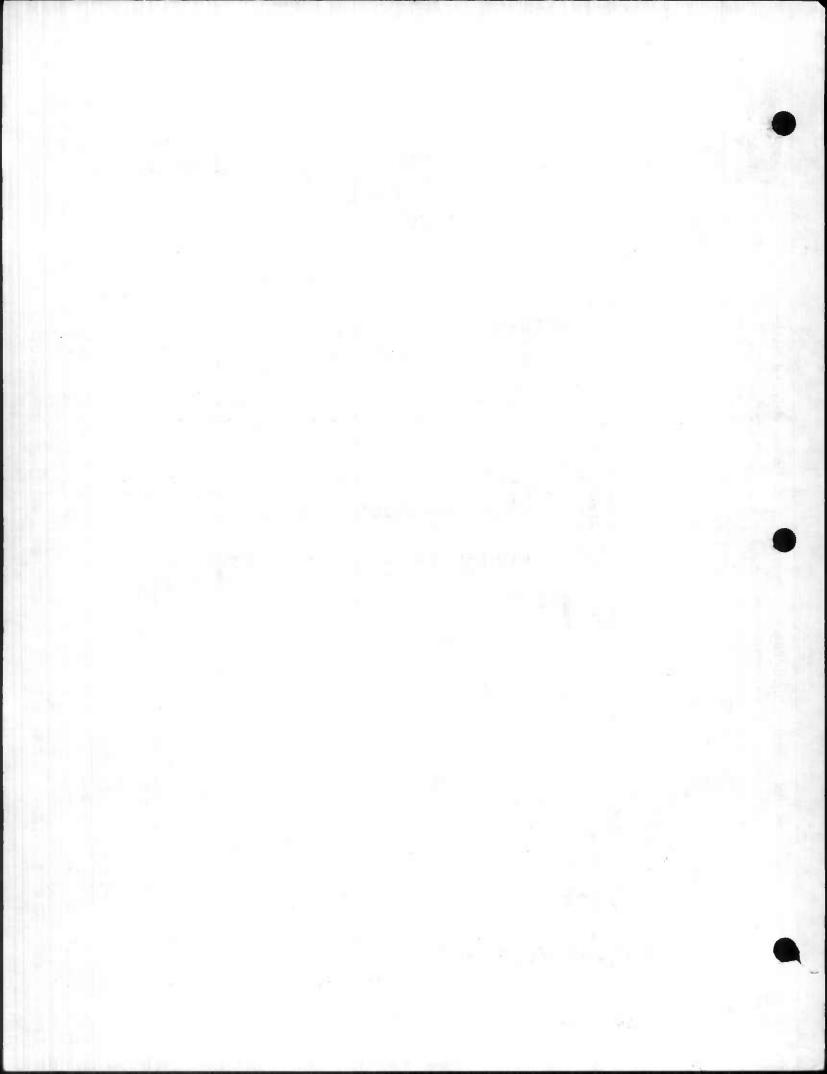
State Registrar

**DHMH 16 Rev 6/95** 

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32. Registrar's Signatura

JAN 2 0 1999



### Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3 Time of Death , Shipley, blick 9:15 PM January 16 4c. County of Death

1. Decedent's Name (First, Middle, Last) **Physician** Samuel 4a Fecility Name (If not institution, give street and number)
SINAI HOSPITAL 4b. City, Town, or Location of Death Examiner IMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Months Deys Hours Min. XXM 2 F 220-44-4853 Yrs **Director** 98 DEC. 18,1900 Usual Residence of Decedent with the Maryland 10a Stete 10b. County 10c. City, Town or Location r 28a-f ehow Director MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiana.
Important: If item 27 is marked other than "---any injury or other treument. "naturel", or items 23s or 3737 CLARKS LANE #405 21215 Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes Æ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Meritel Status 1 Never Merried 2 Married 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PHYSICIAN 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be GLICK MORRIS SARAH 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 3737 CLARKS LANE #405 - BALTIMORE, MD BESSIE S. GLICK / WIFE 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 1/18/99 ANSHE EMUNAH AITZ CHAIM 22. Name end Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD Jolan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting In death) /Medical **Examiner** Due to (or es a consequence of) Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of):

signed by the a peed has

certificate ha this furieral After ector: A 2

Physician/Medical Examiner þ Completed Be 2

To the Hospital or A within 24 hours after To the Funerei Directompletely filled in by

The law requires that the death certificate be exec

Division of Vital Records, P.O. Box 68760, or Attending Physician: Certification: after death.

Pallavi

5 Pending investigation

6 Could not be determined

28c. Injury et Work?

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the desired of the desired occurred at the time, determinent on the best of examinetion end/or investigation, in my opinion, death occurred at the time, determinent of the cause(s) and manner stated.

1 ☐ Yes

Due to (or as e consequence of)

1 Npatient 2 ER/Outpetlent 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

W. Belvedere, Baltimore MD

2 No

29d. Date signed (Month, Day, Year)

Location (Street end Number or Rural Route Number, City or Town, Stete)

Birthpiece (State or Foreign Country)

WHITE

SCHWARTZ

21208

Approximate interval Between Onset and Death

U.S.A.

MEDICINE

BALTIMORE, MD

23b. Did tobacco use contribute to the cause of death?

24a. Wes en eutopsy performed?

28d. Describe how Injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Piece of Death (Check only one)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24b. Were autopsy findings eveilable prior to completion of cause of deeth?

1 ☐ Yes 2 ☐ No

14 Race - American Indian

Bleck, White, etc.

10d. Inside City Limits

1 Yes 2 No

MD

30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) Hospital Sinai

Hospital:

31. Date filed (Month, Day, Year) JAN 2 0 1999

25. Was cese referred to medicel examiner?

29b. Signature end title of certifier

1 Yes 2 No

27. Menner of Deeth

1 Natural 2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

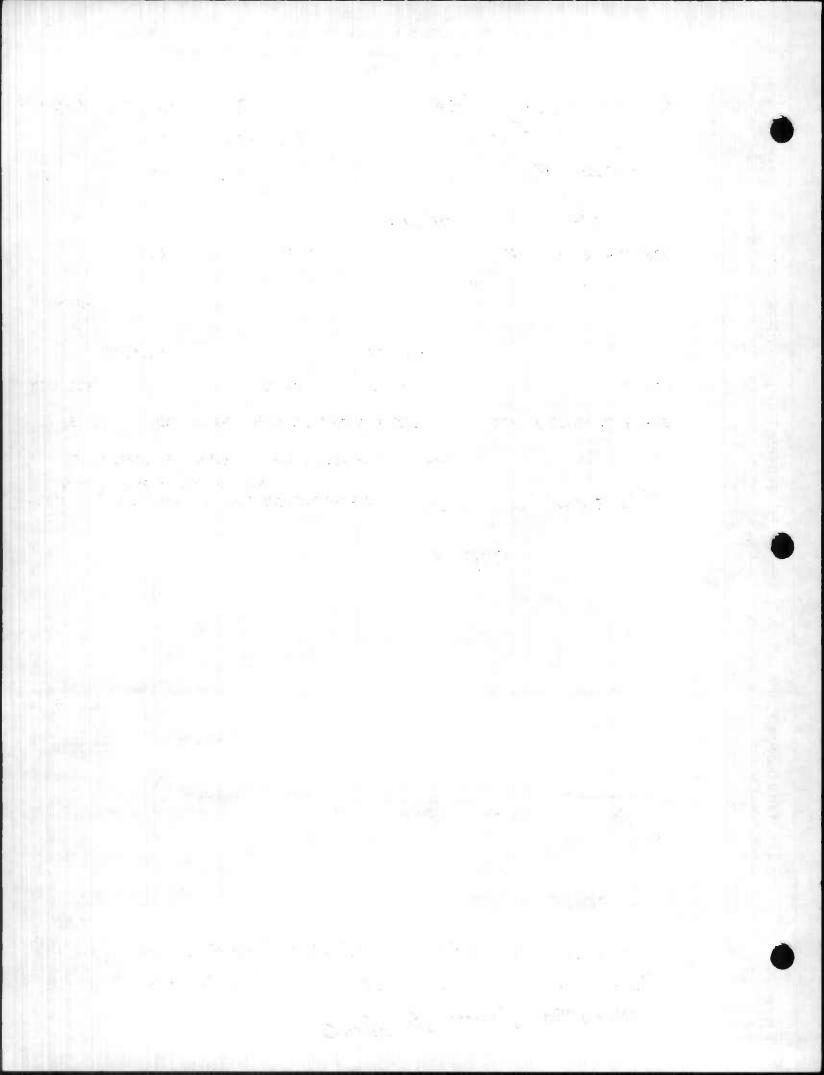
32, Registrar's Signature

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

28e. Date of Injury (Month, Dey Year)

State Registrar

edical



99-0225-510 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. crn State of Maryland / Department of Health and Mental Hygiene Silas Hall, Jr. ITEMS: #27 PER MEO G767 1-25-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Venz Month **Physician** January, 15, 1999 8:12 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Liberty Medical

5. Social Security Number 6. Baltimore If Under 24 Hrs. 8. Center N/A If Under 1 Year 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) 6. Sex 9. Birth Funeral Days 100M 2DF Hours Months Director 60-450 June 27 **Usual Residence of Decedent** or 28s-f show 10a. State 10b. County 10c. City. Town or Location 10d. Wside City Limits 1 Nes 2 No Director MARY And mor et and Number 10e. Str 10f. Zip Code 10g, Citizen of What Country? 6 "natural", or items 23s d Funeral 00 12. Was Decedent Ever in U.S. Armed Forces? 1 (27es 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -11 Marital Status American Indian. Bleck, White, atc. e filed within 72 hours after of Hygiens.
Other then "natural", or her 1 Never Married 2 Married Baltimore, Maryland 21215-0020 # Yes, Give Year or Dates: 1972-1976 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16g. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) VER ONE WOR permit. Pages 1 and 2 should be file Department of Health and Mental Hyy Important: If fam 27 is marked othe any injury or other traumatic avant, pages. 17, Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Amson 19a\_Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Royte Number, City or To md 20b. Place of Disposition (Name of compteny, cremitary or other pla 2/2/2 ATHERINE 20a. Method of Disposition 20c. Location - City or Town, Stele 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ave. 2/22 Son mond 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on with line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cerebral Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown throphrenia of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy this cartificate has 1 Yes 2 No 1 No 2 No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director; I 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 No 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death edical Certification: 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 1 No investigation 2 Accident 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. January 16, 1999 Vermi

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 0 1999

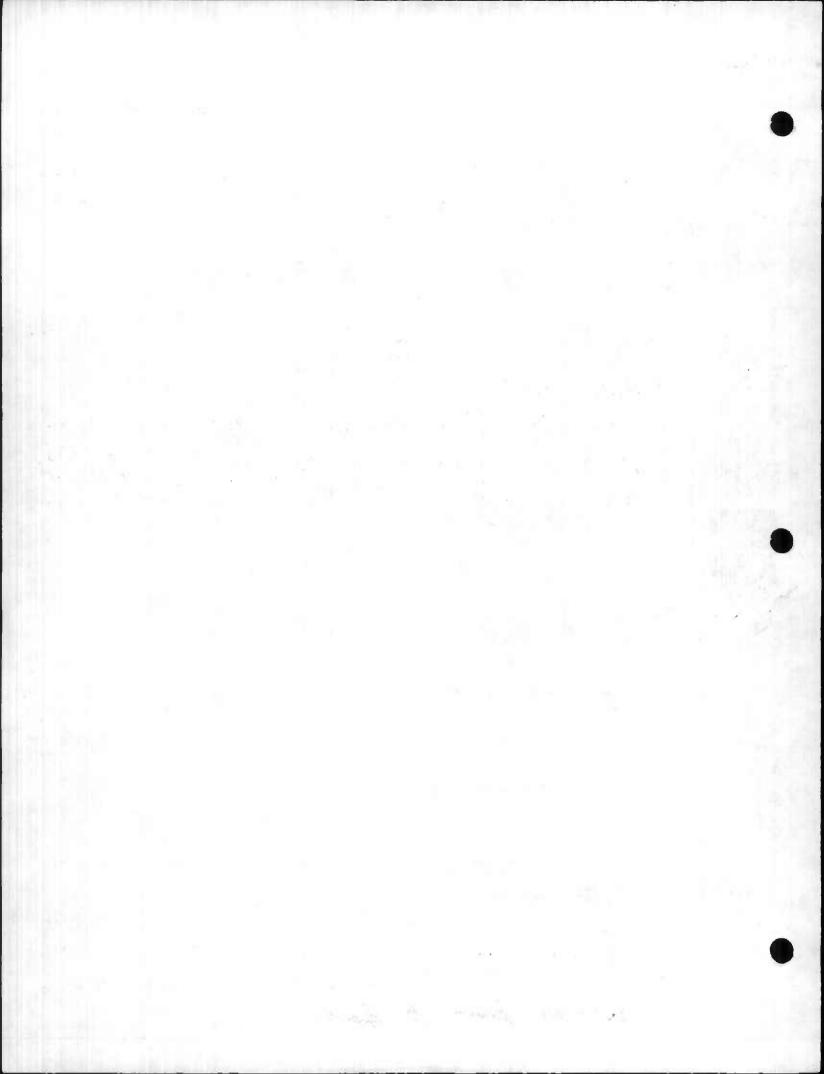
30. Name and address of person y

nnis

111 Penn Street, Baltimore, Maryland 21201.

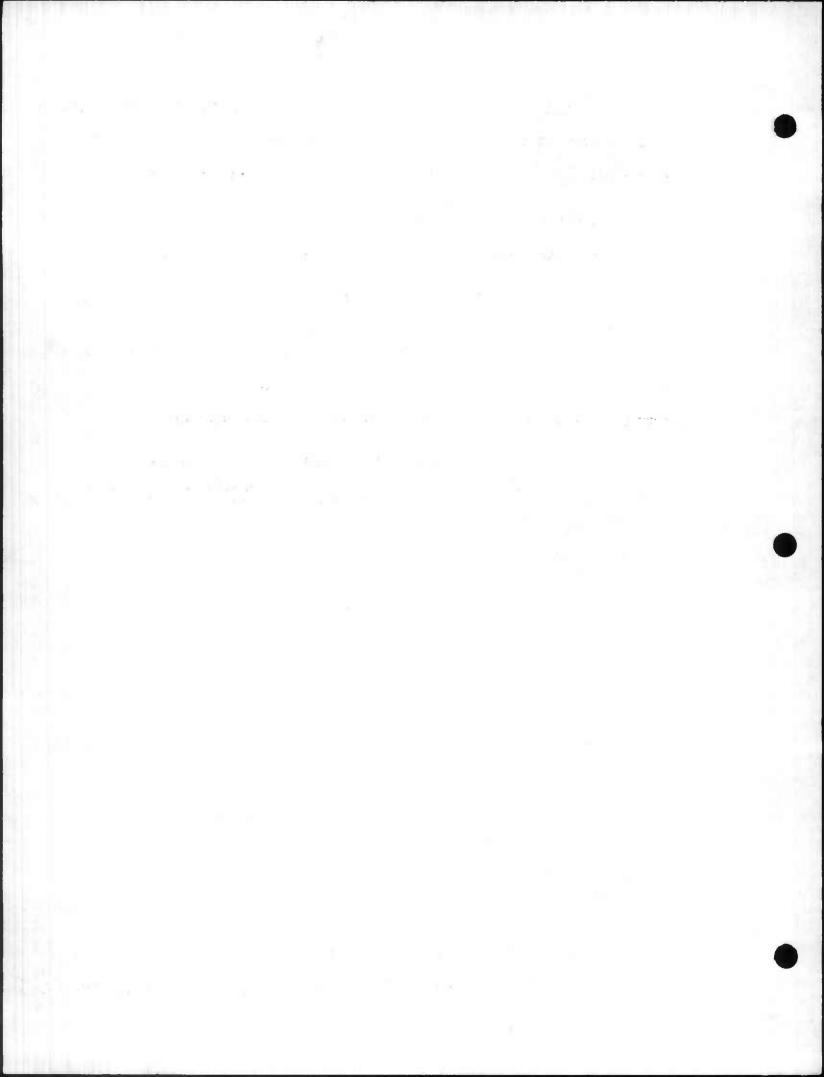
B. Sports

completed cause of death (Item 23a) (Type, Print)



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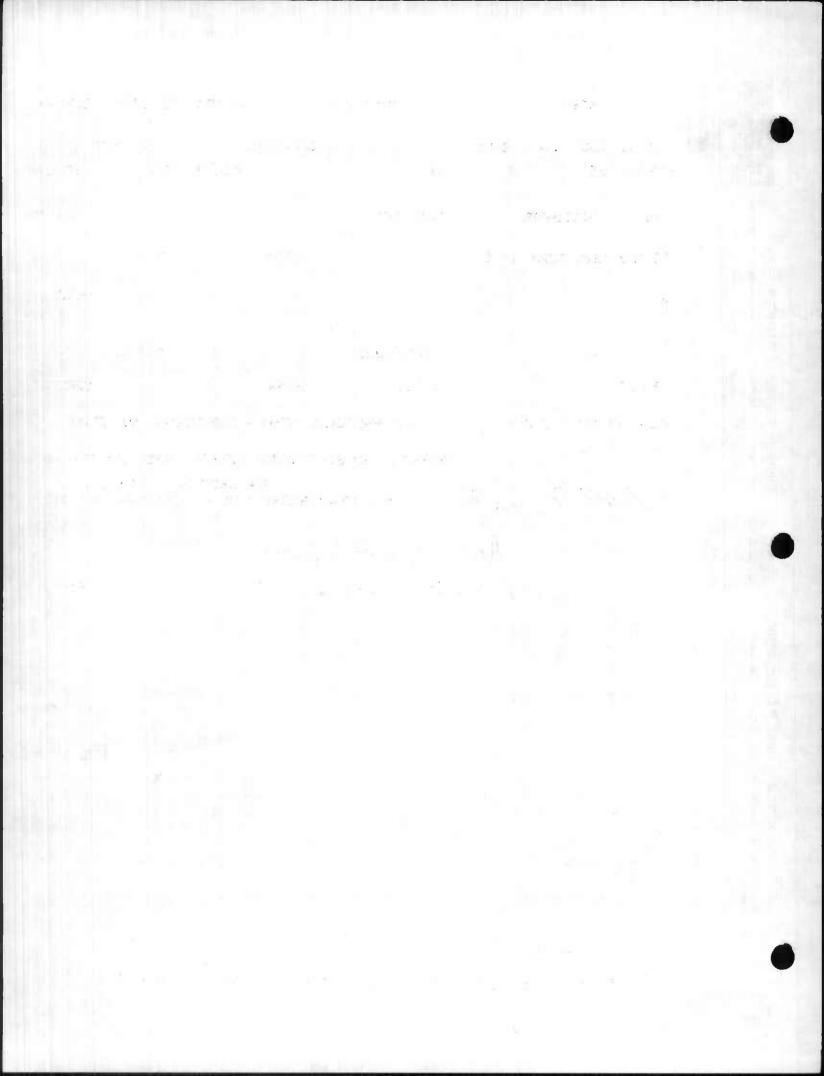
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	Funerai Director		5. Sociel Security Number 219-42-6102 Usuel Residence of Decedent	6. Sex 7. Ag	ja (In yrs. k	est birthdey) Yrs.	If Under 1 Year Months Days			9. Bi 1909	rthpiace (State or Foreign Country) NY
	dand dand		10e. Stete 10b. Count	у	10c. City	, Town or Loca	ation				10d. inside City Limits
	Mary	tor	MD BAL	TIMORE	BAI	TIMORE					1 ☐ Yas 2X No
	or 28	Director	10e. Street and Number				10f. Zip Code		10	Og. Citizen of What C	ountry?
	23a	ral	7920 SCOTTS I					21208		U.S.A.	
21215-0020	within 72 hours after death with the Manyland ienn. than "natural", or liems 23a or 28a-f ehow the Medical Examiner must be notified at	by Funeral	11. Marital Status  12 Never Married 2 ☐ Me 3 ☐ Widowed 4 ☐ Divorce	If Yes Give	Ever in U,S No		as Decedent of I Yes, specify Cub		Specify Yas or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	
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State of Maryland / Department of Health and Mental Hygiené Q 032

					Ce	rtificat	e of	Death		R	eg. No.	00	2012
	1. Decedent's N	ame (First, Middle, La	rst)							2. Date of Deel		Voor	3. Time of Deat
Physician /Medical		ZISEL			G	UZOVS	KY			JANUARY	16, 19	999"	6:31 PM
Examiner	4a Facility Nam	e (If not Institution, giv	va street end numb	er)				4b. City, To	wn, or Loc	ation of Death	4c. County	of Death	
Funeral Director	16 Ol 5. Social Sacuri 219–27			Age (In yrs. I		if Undar Months	1 Yaar Deys	BALT If Under Hours	Main	8. Data of Birth (Month, Dey, FEB 2,		9. Birthi	E plece (Steta or Fon ntry) UKRAIN
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n 24 hours n 24 hours ne Funera pletely fille	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.												
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	Item:17 per F.H G-767 1/	State of Marylar 20/99 reb	Certifica				Reg. No.	00	933		
Physician /Medical			GLAS	SMAN		2. Date of Dea Month	Day	499	3. Time of Death		
Examiner Funeral	4e Facility Name (If not institution, give s  Sinai Hospi  5. Social Security Number 6. Sex	7. Age (In yrs.	Month	1 or 1 Year	Baltimo If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	4c. County N/	4	e (State or Foreign		
Director -	217-03-8826 Usual Residence of Decedent	85	Yrs.			FEB. 9	, 1913		MD		
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th with the Mar 23a or 28a-f a ust be nothled	10e. Street and Number  10f. Zip Code  10g. Citizen of Whet Country  2500 W. BELVEDERE AVE. #306 - BALTIMORE, MD 21215  U.S.A.										
Tuner funer	11. Merital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 No  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuben, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.										
ind 21215-0020 be filed within 72 hours after the triggiene. d other than "natural", or the event, the Wedler Examina Be Completed by Ful		cetion	18e. Decedent's Us (Give kind of viife. DO NOT HOUSEWIFE	work done d use retired	during most of work	ring	16b. Kind of Bu				
Maryland 212 Maryland 212 A should be filed withi th and Mental Hygiene, The merked other than traumatic event, the M To Be Comp	17. Father's Name (First, Middle, Last)  MARC GLASSMAN /	LOUIS HANKOFSKY <del>SON</del>	-		18. Mother's Nem		st, Middle, Malden Sumeme) FRIEDA MISHKIN				
altimore, Maryland mit. Pages 1 and 2 should be flie portant: If them 27 is marked othe y injury or other traumatic event,	19a. Informant's Name/Relationship (Ty) MARC GLASSMAN /	SON	5 COLUMB	INE CO	and Number or Run	LTIMORE	mber, City or Town, State, Zip Code) RE, MD 21209				
imore Pages 1	20a. Method of Disposition  1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	lemoval from State	Place of Disposition (A cemetery, crematory of TH YEHUDA	or other plec		1/17/99	20c. Location - City or Town, State  BALTIMORE, MD				
Baltimo Bantimos Permit. Pages Department of important: It any or once.	21. Signeture of Funeral Service Licensee  22. Name and Address of Facility  SOL LEVINSON & BROS., INC.  8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208										
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Division of Vital Records, P.O. Box 6. or Attanding Physician: The law requires that the death certificate has been signed by the attanding process. After this certificate has been signed by the attanding in by the funeral director, page 2 should be detached for use as ertification: To Be Completed by Physician/Mexernian					24a. Was perio	performed? evailable		autopsy findings able prior to eletion of cause ath?			
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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 3. Time of Death 1 Decedent's Name /First Middle | ast 2 Date of Death Month 9:50 pm Howard K. JANUARY 4b. City, Town, or Location of Deeth 4c. County of Death 1999 4a Facility Name (If not institution, give street and number) Baltimore If Under 24 Hrs. N/A Union Memorial Hospital If Under 1 Year 8. Date of Birth July 15, 1908 Mary and 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2□ F Months Days Hours Min 90 212-07-5206 Yrs Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits YYes 2 No Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3939 Roland Avenue APT 404 21211 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11, Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No ff Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Hardware Sales 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) William Penn Mary Catherine Warhime Harman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3939 Roland Avenue Baltimore, Maryland 21211 Catherine A. Harman (Wife) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 1/20/99 Woodlawn, Maryland 4 ☐ Donation -5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Henss Funeral Home, PA 21211 3631 Falls Road, Baltimore, Maryland on each line. 23a. Pent1. Enter the dimension or complications that shock, or heart failure. List only one cause on Approximate Intervel Between Onset and Death 12 years Due to (or as a consequence of): loyears Cardiomyo Due to (or as e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown tailure 1/A+OR 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was en eutopsy potension 1 Yes 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospitel:

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

rai", or items 23a or 28a-f show Examiner rough be notified at

permit. Peges 1 and 2 should be filed within 72 hours after deeth v. Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or itama 23a any injury or other traumatic avent, the Medical Examine man any nature.

Directo

Funeral

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Completed

with the Maryland

certificate be executed attending physician for use as the burial The law requires that the death signed by the a Deen has page certificate

Physician/Medical Examiner

by

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Certification:

edical

29b. Signeture and title of certifier

30. Neme and address of pending

DUSAN 31. Date filed (Month, Day,

or Attanding Physician: After this funerai eral Diractor: A Hospital 24 hours

Howard Kennard Harman within 2 To the

> State Registrar

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 25. Was case referred to medicel examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

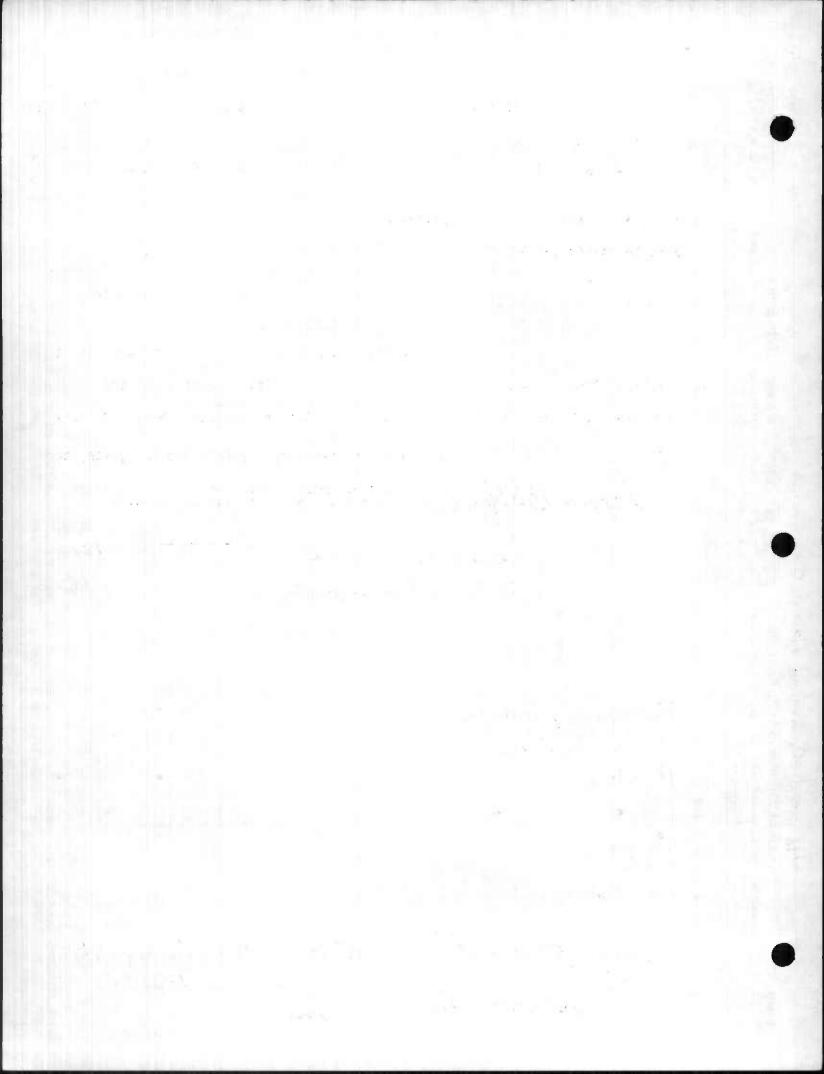
PKWY, Baltimere MD

who completed cause of deeth (Item 23e) (Type, Print)

Registre

201 Eat University

29d. Date signed (Month, Day, Year)



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State of Maryland / Department of Health and Mental Hygiene O

		1. Decedent's Neme (First, Mide	die, Lasti	)		0611	inval	001	/		2. Date of De	Reg. No.		3. Time of Death
	ysician Medical	Anthony				Harr	is	-	JR.		Month JANUAF	Dey 17 1	Year 999	14:25p
Ex	aminer	4a Facility Name (If not institution THE JOHNS HOP)	-								ocation of Deel	h 4c. County	of Death	30.54
Fun	eral	5. Social Security Number	6. Sex	K		last birthday)		1 Year	If Under	24 Hrs.		rth New Year)	9. Birtho	place (State or Foreign
Dire		239-44-1894	1 💢	M 2□ F	66	Yrs.	Months	Days	Hours	Min.	NOV10,	1932	NOR	TH CAROLINA
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with the Maryland a or 28a-f show	be notified Director	MARYLAND			E	SALTIMO	T	0.4			^			
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har dea	Fun Fun	1 Never Merried 2 Ma		Armed For	if	13. Was Decedent of Hispenic Origin? (Specify Cuban, Mexican, Puerto F.)				Rican, etc.)		lack, White, etc.		
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21215-0020 d within 72 hours after plene. or than "natural", or the	Completed	15. Decede (Specify only high	nt's Edu	cation		16a. Decede	ent's Usu	el Occup	ation	et of word	· laa	16b. Kind of B	usiness/In	dustry
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Baltimore, semit. Pages 1 a Department of Nes mportant: If them	E .	4 Donetion 5 Other (Specify)  BALTIMORE CEMETERY  1/22/99 BALTIMORE, MD.											יטויו.	
S Page	900	21. Signeture of Financial Service Licenties  22. Name end Address of Fecility ESTEP BROTHERS FUNERAL SERVICE, P. A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217												
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Physician	shock, or heart failure. List only one cause on each fina.										Intarval Between Onset and Deeth			
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Division or Attending attar death. Director: After	by the	3 ☐ Suicide 6 ☐ Could	not be	28a. Place of tnjury - At home, ferm, street, fectory, office						28f. Location	Street and Numi	ber or Rura	al Route Number,	
D \$ 45	<u> </u>	4   Homicide		building, atc. (Specify)							City of Te	wn, Stata)		
To the Hospital within 24 hours a To the Funeral														
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To With	E 2	29b. Signeture end title of certifi	er				29	c. Licens	e number			29d. Date signs	d (Month,	Day, Year)
		Stown	5-	Salan	HOUSE	OFFICE	KI	RES	5-00	0		January	17.10	999
0		30. Name and address of person	who co	mpleted cause						-			1	

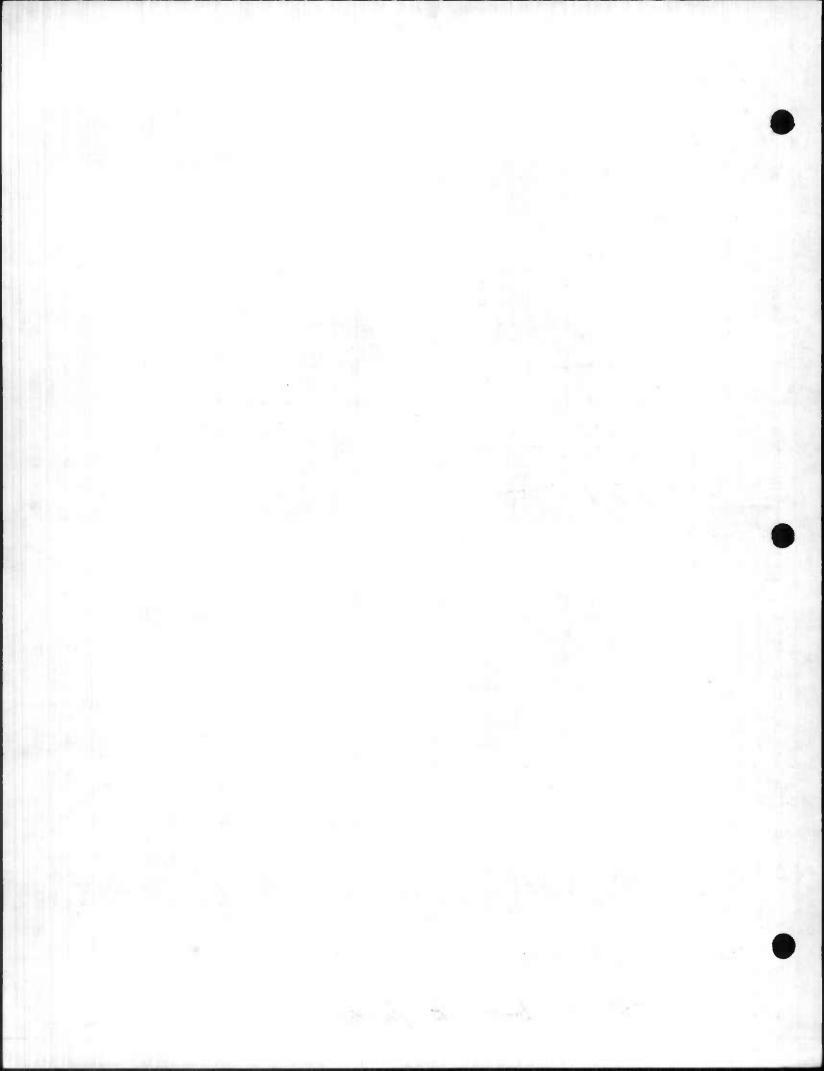
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Steven Francis Solga 31. Dete filed (Morth, Day, Year) JAN 20 1999

Registrar

DHMH 16 Rev 6/95

Tower 110, 600 North Wolfe Street, Johns Hupkins Huspital, Bultman, mo 2/287



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death Month **Physician** FRED HOLLOWAY 2:10 AM JANUARY 19 1999 /Medical 4e Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE MARBOR CENTER NIA HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex / 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (Steta or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Days Hours 243-18-9693 NC Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inaide City Limits 1 Yea 2 No NIA MD BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ST 21213 N. WASHINGTON 1610 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: t4. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If itam 27 is merked other than "natural", or item any injury or other traumatic event, the Medical Event 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: BLACK by 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buainass/Industry Elementary/Secondery (0-12) College (1-4or 5+) SHIPPING NIA SHOREMAN 6 TH GRADE 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) AMANDA MACK HOLLOWAY HOMAS 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ST. 1610 N. WASHINGTON BALTO. KUTH TAISON JAUGHTER MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removel from State 1-25-99 LAUREL NATIONAL 4 ☐ Donetion 5 ☐ Other (Specify) CEMETERY 21. Signeture of Funerel Service Licenses 22. Neme end Address of Facility C. GREENE FUNERAL SERVICE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart a limit only one cause on each line. Approximate Intervel Between Onsat and Death SEPSIS tmmediate Cause (Final disaese or condition rasulting in deeth) one day Due to (or as a consequence of): Physician/Medical Examiner PNEUMONIA Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): URINARY TRACT INFECTION Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yat 2 No 3 Probably 4 Unknown HLZHEIMER'S DISEASE þ 24b. Wera autopsy findings available prior to completion of cause of death? edical Certification: To Be Completed 24a. Wes an autopsy performed? 1 Yas 21 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 (Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 1 DNatural 5 Pending investigation 1 Yes 2 No 2 Accident

The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, Physician:

After this

after death.
I Director: Aff

To the Hospital within 24 hours a To the Funeral C completely filled Hospital

or Attending

**Physician** 

/Medical

Examiner

Director

rai", or items 23a or 28a-f show Examiner must be notified at

the Manyland

Baltimore, Maryland 21215-0020

3 Suicida 4 Homicide

6 Could not be determined

28e. Place of Injury - At home, larm, street, lectory, office building, etc. (Specify)

281. Location (Street end Number or Rurel Route Number, City or Town, Stele)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifier

0

29a. Certifier

MD

29c. License number as 244 1614 A15

29d. Date signed (Month, Day, Year) JANUARY

MD 21225

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

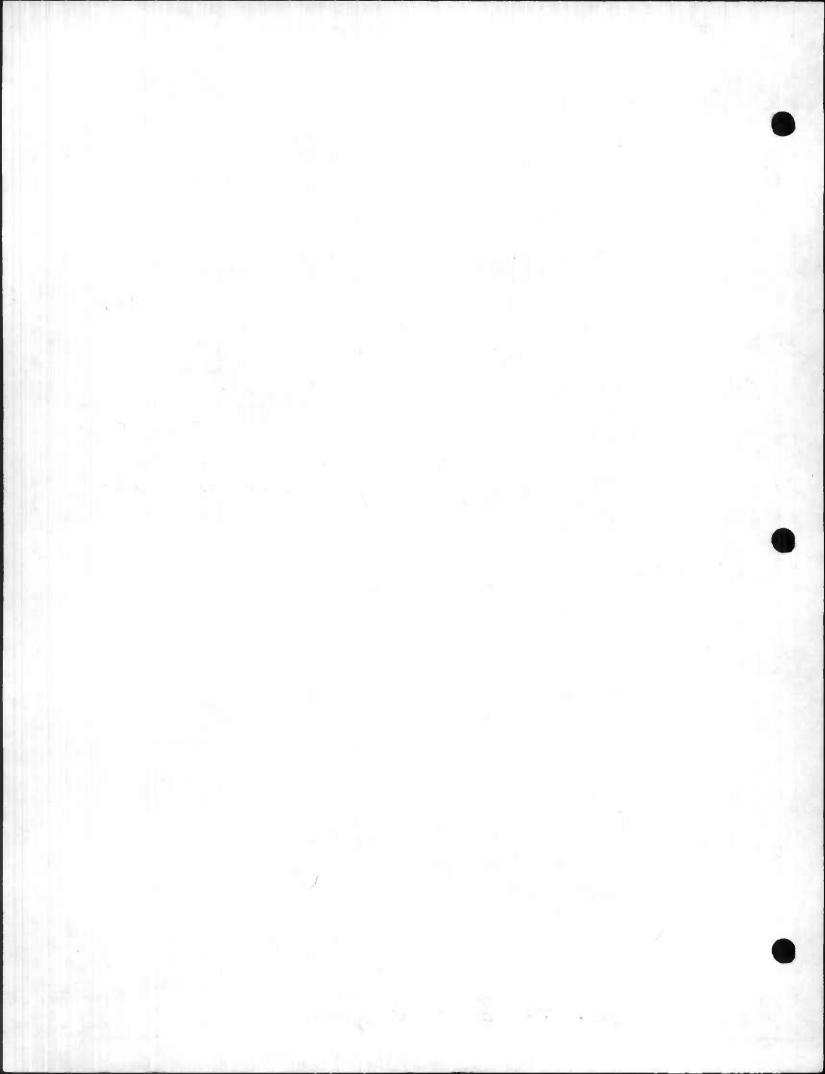
JA YALA KSH MI BALASUBRAMANIAN 31. Date filed (Month, Dey, Year)

JAN 2 0 1999

32. Regi frai s Signature

S. HANOVER ST. BALTIMORE 3001

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 26 per M.D G-767 1/20/99 reb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan. 18, Day 999 Year Alva G. Harris 2130 4a Facility Nema (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll County Gen. Hospital Carroll Westminster 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 264–16–7341 8. Date of Birth (Month, Day, Year) Feb. 18,1910 Birthplace (State or Foreign Country) Months Days Hours Sweden Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 1 Yes 2 □ No Md. Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3208 Main St. 21102 U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, 11 Merital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Segondary (0-12) College (1-4or 5+) Shipping Clerk Black & Decker 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Margarta Erickson Anders Axil Graaf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Harris 3208 Main St., Manchester, Md. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Lutheran Cem. Jan 21, 1999 Manchester, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Eckhardt Funeral Chapel 3296 Charmil Dr., Manchester, Md. 21102 installe, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, unit. List only one cause on each lina. 23a. Part1. Enter the shock, or heart Approximata Interval Between Onset and Death Immediate Causa (Finel Intarction Myocardia Minutes disease or condition resulting in death) enosis Years Due to (or es a consequence of) Due to (or as a consequence of): Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? Heart 1 Yes 2 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medicat examiner?

**Physician** /Medical Examiner

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funeral director.

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After

24 hours after death.

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Medical Certification: To

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records.

or Attending Physician:

Hospital

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed

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**Funeral** 

Director

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filed within

Pages 1 and 2 abound be fit ment of Health and Mental H tant: If Item 27 is marked off jury or other traumatic ever

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Physician/Medical þ Completed

26. Place of Death (Check only one)

Hospitat: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Home 5 Providence 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be datermined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier (Check only one)

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted.

MI 00051924 1-19-99

29d. Data signed (Month, Day, Year)

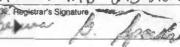
30. Nema and addrass of person who completed causa of death (Item 23a) (Type, Print) Herbert P. Hen Olevson Jr. MD 295 295 Stoner Ave Ste 307 Westminster MO 21157 P. Hen derson MD Herbert

29c. License number

State Registrar

31. Data filed (Mooth, Bay, Year)

29b. Signature and title of certifier



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 3 8

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Year Month **Physician** VAN Lucille R. Houser 1999 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not Institution, give street end number) 4c. County of Death Examiner 5T. BALTIMORE AGNES HEALTHCARE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 5. Social Security Number Birthplace (State or Foreign Country) Funeral Months Days Hours Yrs Director 218-14-7820 74 Maryland Jan. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at XXYes 2 No Directo Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21223 316 South Norris Street Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritai Status filed within 72 hours aftar Yes 2X No 1 Never Married 2 Married 10. aitimore, Maryland 21215-0020 1 ☐ Yes 2XXNo White If Yes, Give ' Year or Dates à 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Housewife Own Home other permit. Peges 1 and 2 should be file Department of Haalth and Mental Hy important: If item 27 Is marked othe eny injury or other treumatic event ands. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Myrtle R. Haddaway Charles Nagle 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) John C. Houser, Jr./Son 101 Harford Road Glen Burnie. MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/18/99 Maryland Loudon Park Cemetery Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Gary L. Kaufman F.H. @ Meadowridge Mem. Park, Inc 7250 Washington Blvd., Elkridge, 21075 the or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, at last only one cause on each line. Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medicai **Examiner** Coronary Atherosclerosis, marked vears Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): physician and s the burief-tran Physician/Medical Due to (or as a consequence of): USB as t 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed by t 1 Yee 2 No 3 Probably 4 Unknown Surgical site infection with Methicillin resistant þ 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed Staphylococcus aureus. completion of cause of death? page 2 certificata has 1 PYes 1 Des 2□ No Hypokalemia. the funeral director, Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To After this 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Natural death. 1 Yes 2 No 2 Accident after death Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 8 Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end manner as stated Medical 29e. Certifier completaly 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and piece, end due to the cause(s) and manner stated. (Check only one) within 2 94 29c. License number 29d. Date signed (Month, Dey, Year) 0 D09990 January 16,1999 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Dr. Michael E. Pelczar, St. Agnes HealthCare 900 Caton Avenue, Baltimore, MD 21229

State Registrar

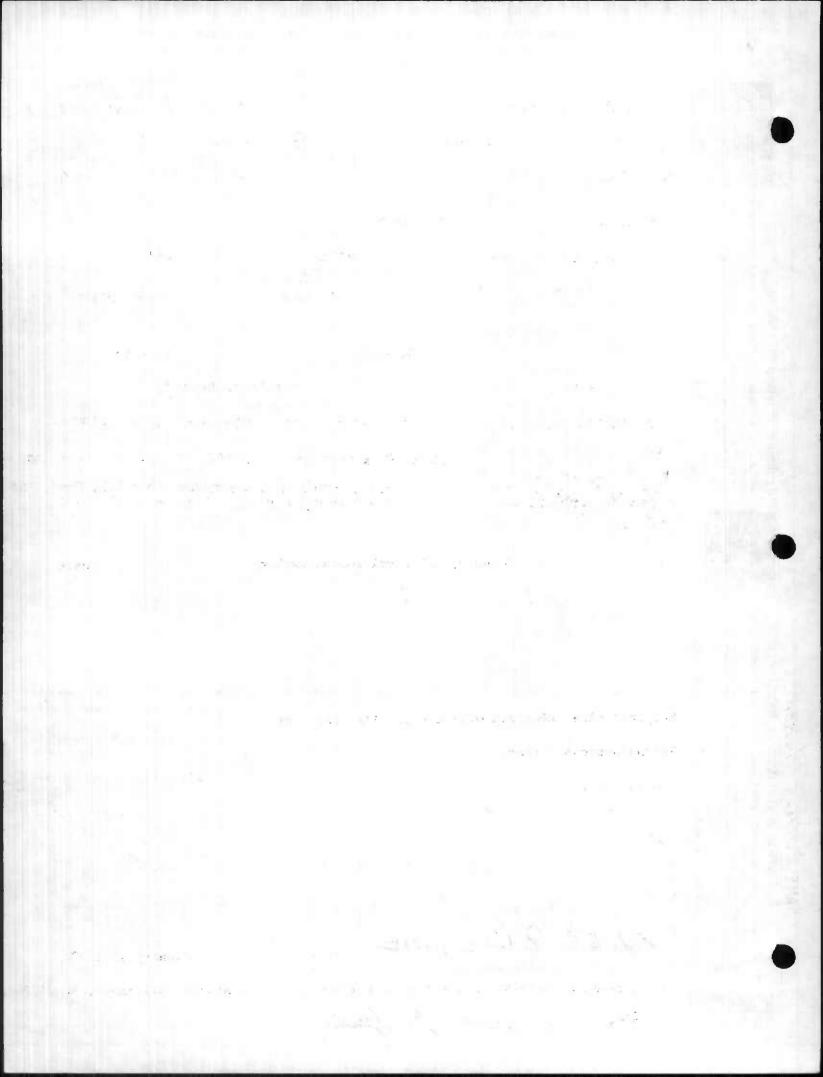
DHMH 16 Rev 6/95

NAME LUCILLE HOUSER

JAN 2 0 1999

31. Date filed (Month, Day, Year)

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** Laura E. Hoenig January 15, 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Genesis & 5. Social Security Number Bysaklyn Park If Under 1 Year If Under 2 Hrs. 8. Del Months Deys Hours Min. (Mo N/A M 3 2/225 Elder Carle Center 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) Birthpiece (State or Foreign Country) **Funeral** Months 1□ M 2□ F 218-42-7679 91 Yrs. **Director** MAY 15, 1907 Maryland Usuel Residence of Decedent 10a. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No MD N/A Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 East Fort Avenue 21230 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritel Status filed within 72 hours aftar 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Merried 1 ☐ Yes 2XXNo Specify: white by 3 ☑ Widowed 4 □ Divorced Yeer or Detes Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 end 2 should be filed v Department of Health end Mental Hygies Important: If item 27 is marked other th any Injury or other traumatic avent, the pncs. Homemaker Own Home 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Louis R. Springer Lena Adams 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Irene L. Rutkowski - daughter 212 East Fort Ave., Baltimore, Md. 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1/19/99 1)(Burial 2 Cremation 3 Remove from Stete Meadowridge Mem. Park Elkridge, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 7250 Washington Blvd., Elkridge, Md. e, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediete Ceuse (Finel diseese or condition resulting in deeth) arteroselente cardo vagarlas dreace /Medical Examiner Due to (or es e consequence of): Examiner d resie COVOMMY elne artery deeth certificate be executed sician and buriel-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to ( r es e consequence of); physician Physician/Medical the Due to (or es e consequence of) 189 es ettending p signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy tindings aveileble prior to completion of cause of death? Completed 24e. Wes an autopsy page 2 : 1 Yes 2 No or Attending Physicien: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturei 2 Accident 5 Pending after death. Director: Aft investigation 1 Yes 2 No the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner steted. 29e. Certifier edicai completely (Check only one) within 2 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of cartifier 29c. License number 019512

State Registrar

altimore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital Records,

**DHMH 16 Rev 6/95** 

SANG C.

31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture 1999

1600 Crain

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

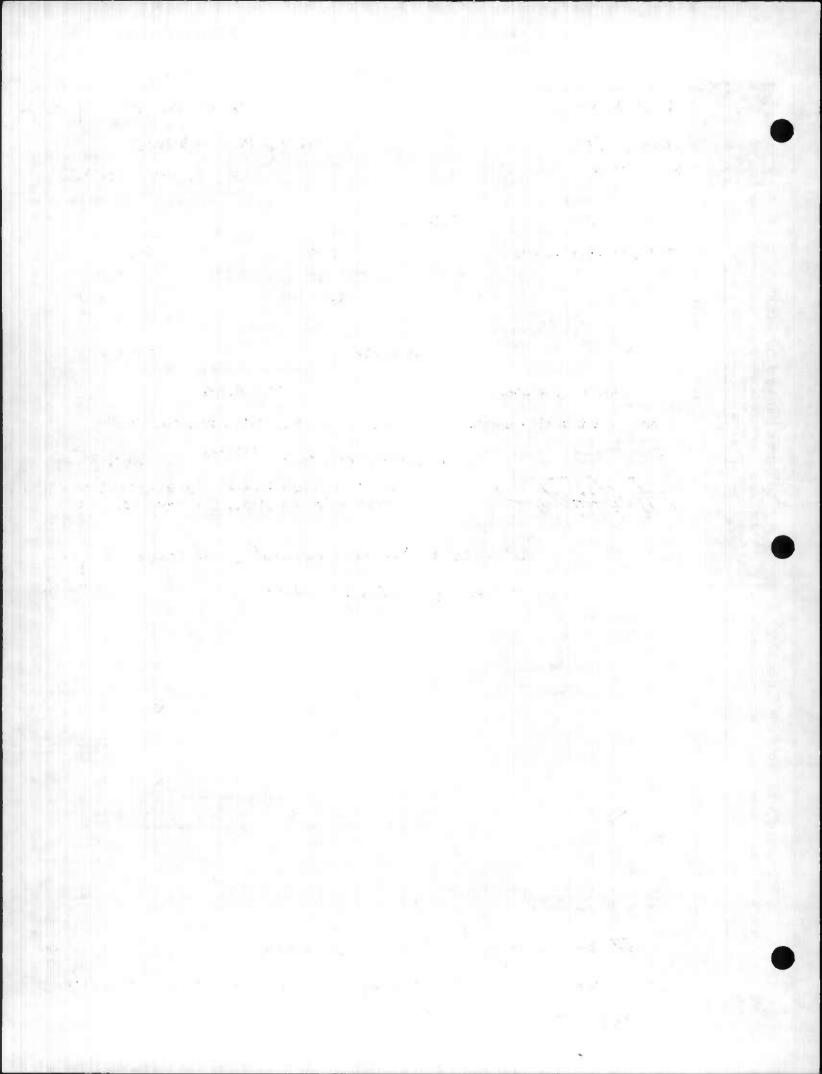
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Hoghway

, surte 206 Glem Burnie,

MD 2106



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JANUARY 15, 1999 M. CLARA HAMENT 6:20 AM 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) GENESIS BRIGHTWOOD NURSING HOME LUTHERVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthpiace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours 1 M 200 F Yrs. 216-46-8786 APR. 29, 1901 97 MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 130 SLADE AVENUE 21208 U.S.A. #622 14. Rece - American Indian, Biack, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 🗓 No Specify: 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HARRIS ROSENBERG SOL SADIE 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #302 - BALTIMORE, MD 21208 CARROL HAMENT / SON ONE SLADE AVENUE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEMETERY 1/17/99 BALTIMORE, MD re of Funeur Service Liebnse 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure
Due to (or as a consequence of): pertension Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dementio 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 Yes 2 00 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medice examiner? 28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

certificate be specy attending physician The law requires that the deeth ed by the a 0 signed t been s cartificate has page Physician: this funeral ne Hospital or Attending P n 24 hours after death. After t the 3

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

r than "natural", or items 23s or 28s-f show the Medical Expendent must be notified at

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Physician/Medical Examiner

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permit. Pages 1 and 2 should be file Depertment of Hastin and Mental Hy Important: if flem 27 is marked oth any finjury or other traumatic event RREs.

**Physician** /Medical

**Examiner** 

Box 68760. Division of Vital Records,

> within 2 0

(Check only one) 29b. Signeture end title of certifier

29c. License number

2 Medical Examinar: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the ceusa(s) and manner stated. 29d. Date signed (Month, Day, Year)

January 15, 1999

30. Name and address of personal to completed ceuse of deeth (Item 23e) (Type, Print) Craig Gold DO 4000 Old Court Road #306

Baltimore, Maryland 21208

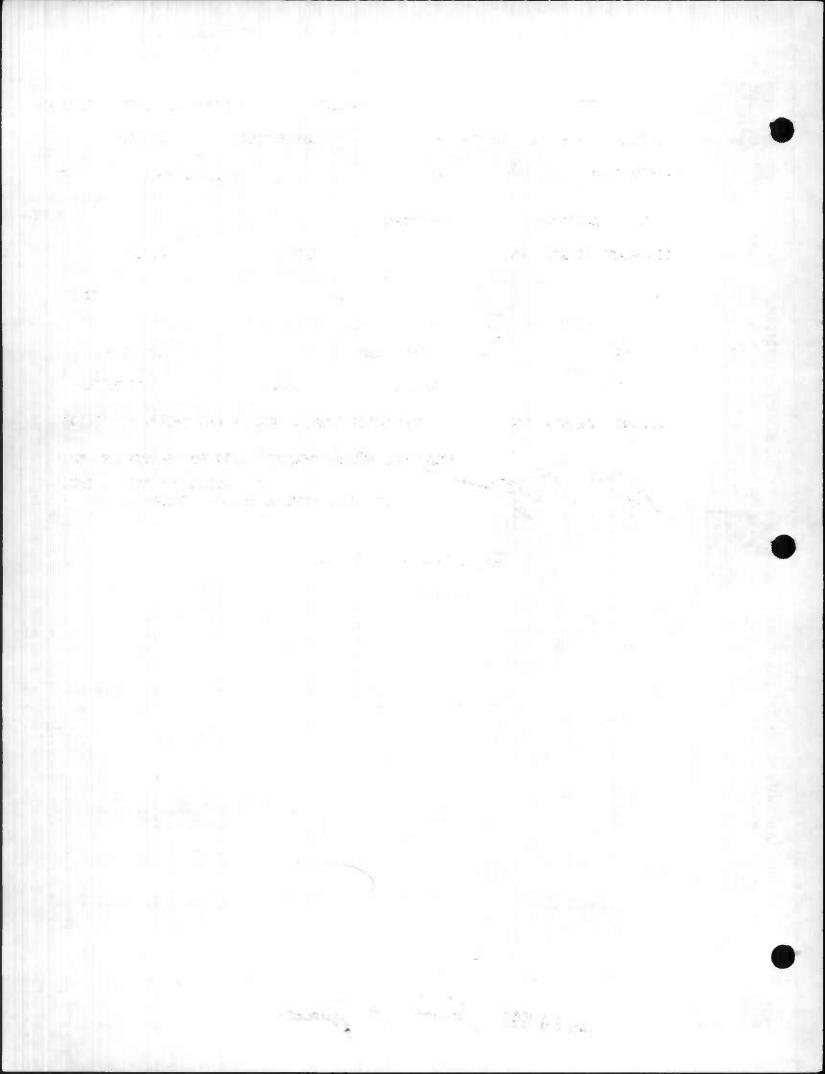
State Registrar

31. Dete filed (Month, Day, Year) # \* JAN 2 0 1999

32. Registrar's Signature

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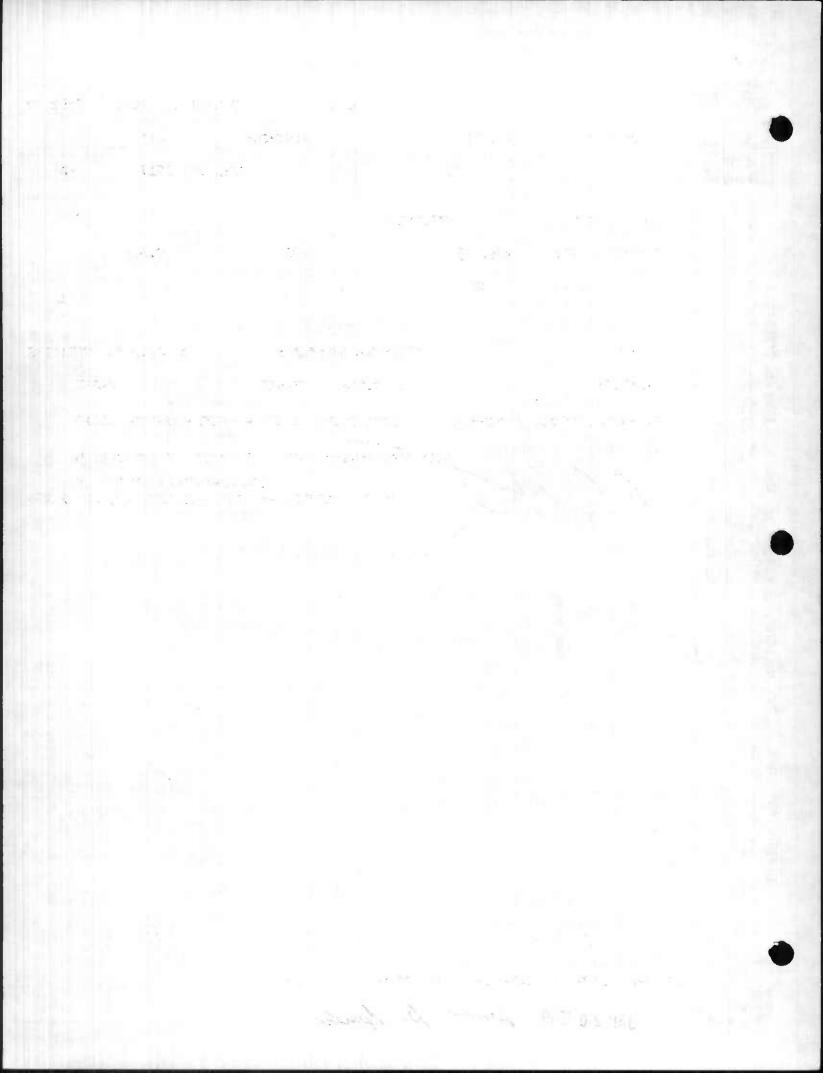
锅 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end manner as stated



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

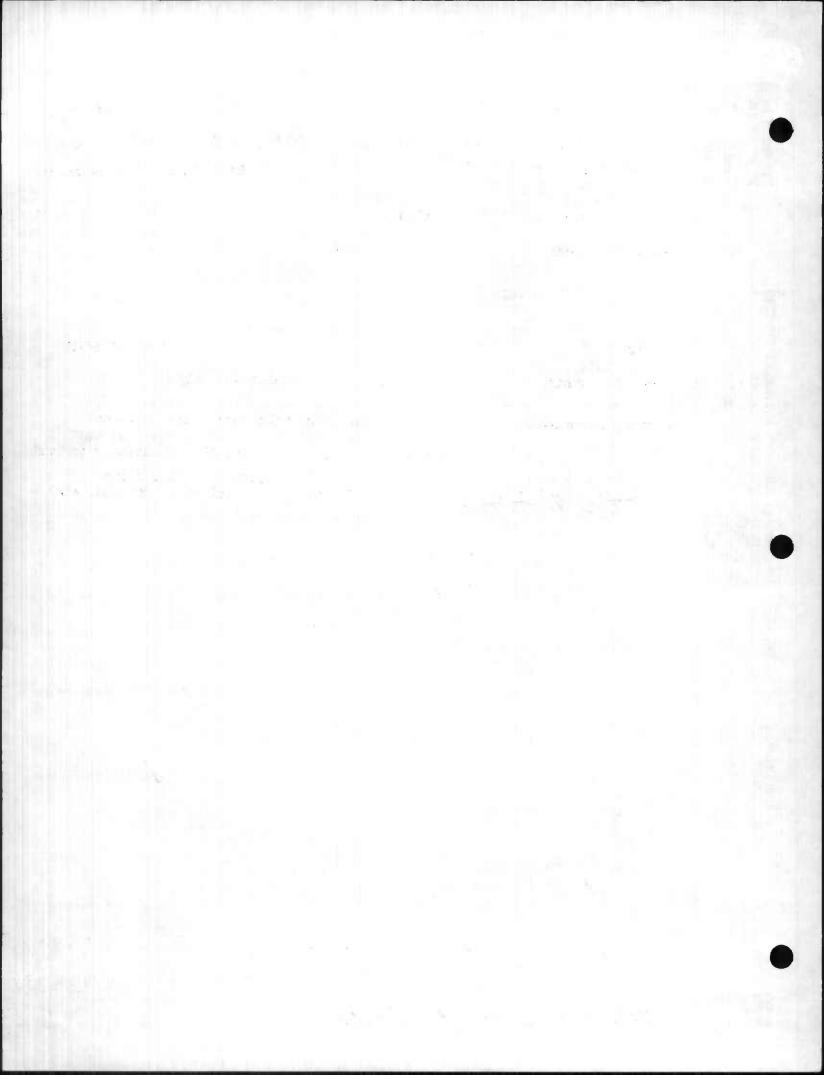
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Tima of Death **Physician** ELLEN HANKIN JANUARY 15, 1999 3:52 PM /Medical 4e Facility Neme (If not institution, give streat and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 1 HAMIL COURT APT. 31 BALTIMORE N/A 8. Dete of Birth (Month, Dey, Year) APR 20, 1 If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) **Funeral** 10 M 2 F Months Deys Hours Yrs. 81 217-20-4395 MD Director Usuel Residence of Decedent Pages 1 and 2 should be filled within 72 hours efter death with the Maryland nent of Heelth and Mentel Hyglene. Intil I Hear T2 I a marked other than "naturel", or items 23a or 23a-f ahow miss I death or the traumatic event, Tre Medical Experiment matt be notified as my or other traumatic event, Tre Medical Experiment matt be notified as 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits XXYes 2 No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 HAMIL COURT APT. 30 21210 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, afc.) 14. Race - American Indien, 11. Maritel Status Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. þ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Collaga (1-4or 5+) 12 EXECUTIVE SECRETARY ASSOCIATED CHARITIES 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fathar's Nema (First, Middla, Last) Be **ISADORE** SILVERMAN TILLIE BARRE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) # 30 - BALTIMORE, MD DR. SAMUEL HANKIN / HUSBAND 1 HAMIL COURT 21210 20b. Plece of Disposition (Name of cemetery, crematery or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☑ Burlel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) permit. Pege Department of Important: If any injury or once. ARLINGTON CHIZUK AMUNO 1/17/99 BALTIMORE, MD 21. Signature of Funeral Service License 22. Name end Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23e. Pert1. Enter the diseasa, or complications thei caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate intervel Between Onset and Deeth **Physician** /Medical immediate Ceuse (Finel The ho disaasa or condition resulting in deeth) Examiner Due to (or es à consequence of) Examine ance Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events rasulting in daeth) Lasf Due to (or es e consequença of) Records, P.O. Box 68760, **Physician/Medical** Due to (or es e consequence of): 98 signed by the e 23b. Did tobacço usa contributa to the causa of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 1 □ Yea 2 □ No 3 □ Probably 4 □ Unknown p 24b. Were autopsy findings eveilable prior to complation of causa of death? been si 24e. Wes en eutopsy Completed performed? s certificate has b 1 Yes 2 No 1 Yes Division of Vital Attending Physician: 25. Wes case referred to medical axaminar? 26. Piece of Deeth (Check only Be Othar: 4 Nursing Home 5 Phesidence 8 Othar (Specify) 2 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yas/ th Is 28e. Dete of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident after deetl Director: n 24 hours after dee ne Funeral Director nietely filled in by the 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 6 29a. Certifier 1 🔯 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete and plece, and due to the cause(s) and manner as stated To the Hosp within 24 ho To the Fune completely fi Medical 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted. (Check only one) 29d Date stoned (Month, Day, Year) 29b. Signeture end title of partition 29c. Licansa number 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) DR. GWEN DU BOIS 7300 YORK ROAD TOWSON MD. 21204 31. Data filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar JAN 2 0 1999



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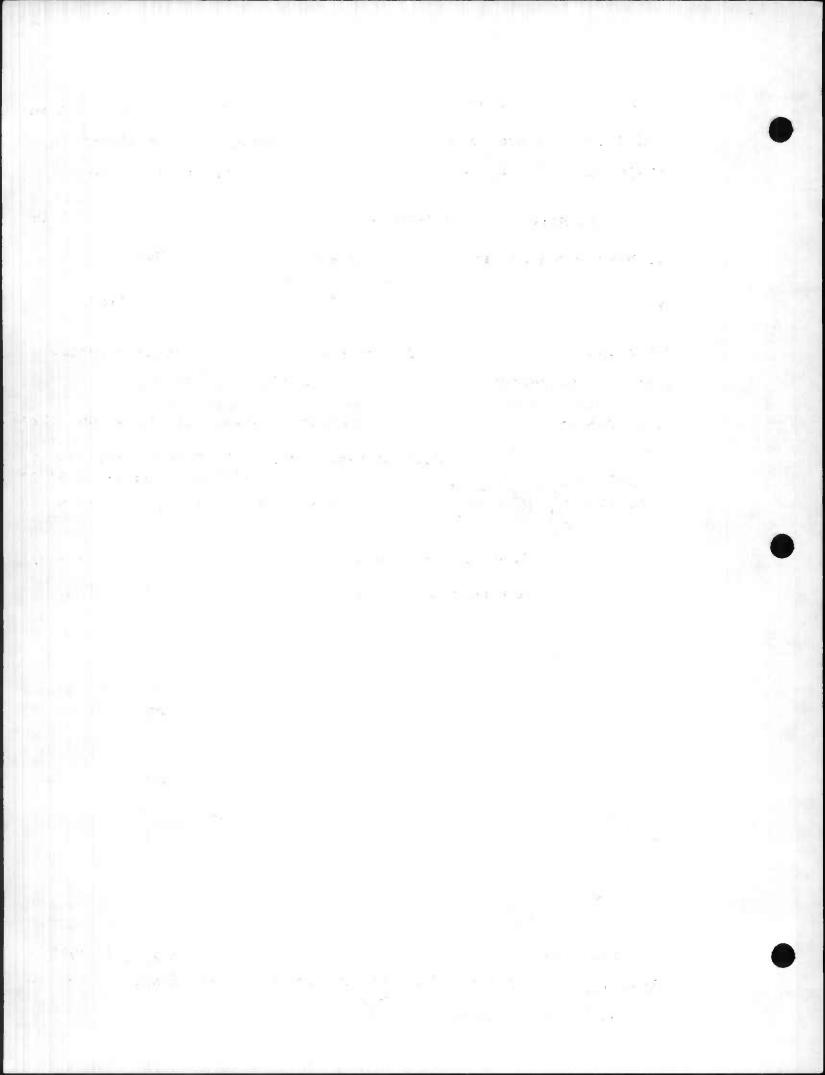
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MD Baltimore Parkville    10e. Street and Number   8663 Oak Road   10f. Zip Coda   21234										og. Citizen of What Country? U.S.A.		
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The Person Name and Address of the Person Name and Address of			Removel from State	20b. Place of Disposition (Nama of cematary, cramatory or other place) Parkwood Cemetery					1/20/99 Baltimore, Maryland			
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State of Maryland / Department of Health and Mental Hygiene Q 001, 2

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	728 Peach Ord			da) If I Inde		Dunda.	L K 8. Date of Birth	Baltimore			
Funeral Director	5. Social Security Number 237-18-0024  Output										
fand W	10e. State 10b. County 10c. City, Town or Location									10d. Inside City Limit	
Many Many	MD Dundalk Baltimore									1 Yes 2 N	
rec	10e. Street end Number 10f. Zip Code 10g. Citizen of Wi									ry?	
3a O	728 Peach Orch	ard Lane			21222			USA			
The state of the s	11. Maritel Status  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:	er in U,S.	in U.S.  13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto  1  Yes  MNo Specify:			pecify Yes or No- b Rican, etc.)  14. Rece - Am Bleck, Wh Specify: B 1				
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and Mental Hygiene. Is marked other than raumatic event, the Mr. To Be Comp.		NA	S	upervi	sor			Dieta	ry De	ept.	
d other	17. Father's Neme (First, Middle, Last)	7					e (First, Middle, N		10)		
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and Men is marke aumatic	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. I	Meiling Addres	a (Street and h	lumber or Ru	ral Route Number,	City or Town,	State, Zip	Code)	
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	20e. Method of Disposition		20b. Piace of D	Disposition (Na	me of other place)		Date	20c. Location -	City or Tov	vn, State NC	
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6	30. Neme and press of person who co	Johns Ho			ew Med	d. Ctr	. 8114	Sandp	iper	Circle	
State	31. Date filed (Month, Dey, Year)	32. Registrar's		1 10000	· KA						



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 6.34 pm JACKSON SARAH 1999 JANUARY 14 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth HOSPITAL BALTIMORE CENTER HARBOR n/a If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) unknown 8. Dete of Birth (Month, Dey, Year) Days Months Hours 1 M 35F 223-28-2210 89 Nov. 15, 1909 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits n/a Baltimore 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3235 Yosemite Avenue 21215 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes Stor No If Yes, Give Year or Detes: 11. Merital Status 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Merried 1 Yes 2 Tho Specify. Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Montgomery Ward mentary/Secondary (0-12) College (1-4or 5+) Dept. Store 12th Grade Sales Clerk 18. Mother's Name (First, Middle, Maiden Sumame) unknown 17. Father's Neme (First, Middle, Last) unknown 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type. Print) Great-Denise S. McNeal niece 2839 Seamon Avenue Baltimore, Md. 21225 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Buriel 2 Cremetion 3 Removel from State Arbutus Memorial Park Jan. 19 Baltimore, Md. 4 Donetion 5 Other (Specify 21. Signature of Funeral Ge 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Parl 1. Enter the disease, or complications that diused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heef failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in death) SEPSIS DAY Due to (or as a consequence of): 1 DAY RIGHT PNEUMONIA LUNG Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): STAPHYLOCOCCUS AUREUS ENDOCARDITIS I MONTH Due to (or es e consequence of) END STAGE RENAL FAILURE Pert tl. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown HYPERTENSION 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to DEMENTIA completion of cause of death? 20 No 1 Yes 2 No 25. Was case referred to medical examiner?

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Day, Year)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Md.

Director

Funeral

by

**Funeral** 

**Director** 

7 is marked other than "natural", or items 23s or 28s-f show traumetic avent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic avant, the Medical Exercises.

Baltimore, Maryland 21215-0020

Examiner

Physician/Medical þ Completed Be Certification: To 27. Manner of Death

attending physician and for use as the burial-transit this after death.

Director: Aft
d in by the fur

Box 68760. Division of Vital Records, P.O. or Attanding

To the Hospital o within 24 hours aff To the Funeral Di completaly filled in

State Registrar

**DHMH 16 Ray 6/95** 

edical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOWZANYA 31. Date filed (Month, Day, Year)

Sow

29b. Signature end title of certifier

1 Yes 2 No

2 Accident

3 ☐ Sulcide

29a. Certifier

4 Homiclde

(Check only one)

5 Pending investigation

6 Could not be

NAGABHIRAVA 32. Registrar's Signature JAN 2 0 1999

Hospitel: 1 Inpatient

28a. Date of Injury (Month, Dey Year)

2001 S. HANOVERST, HARBORHOSP. CENTER, BALTIMORE, MO

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Yes 2 No

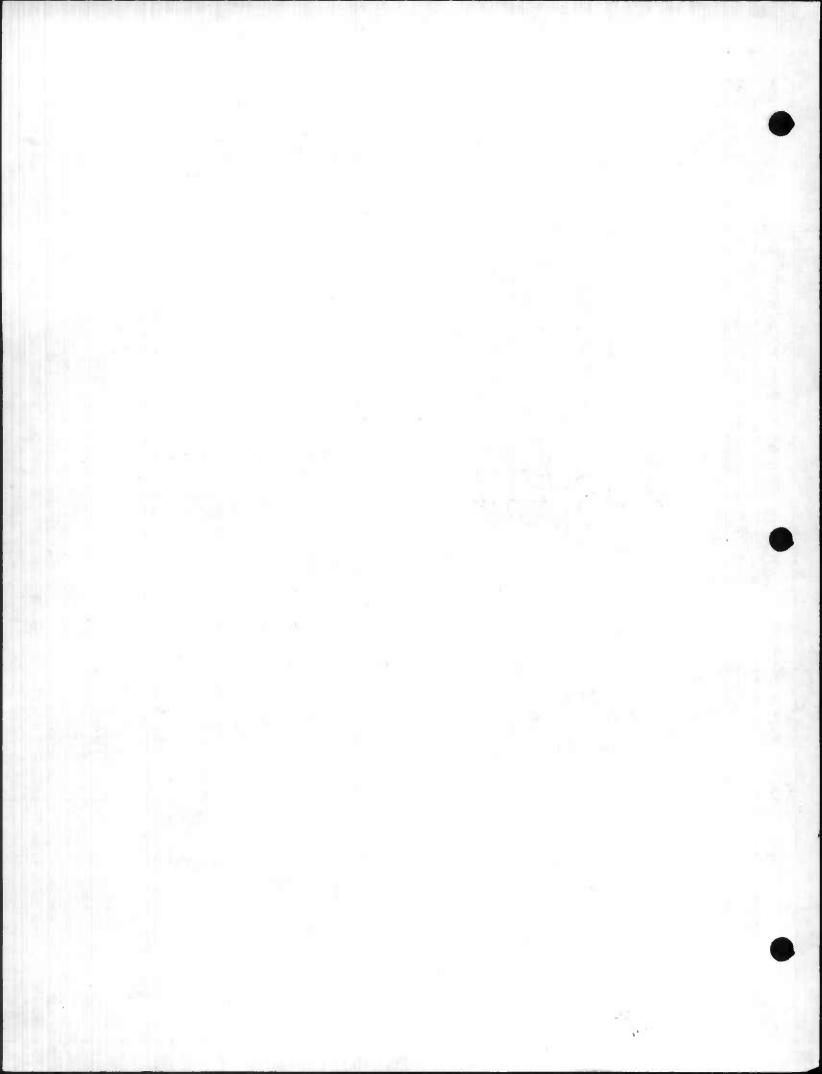
28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

books

PGY-IR RESIDENT AS ZUG1614-A8

**ORIGINAL** 



### Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Kina 19:00 P.m January 17 1999 4b. City, Town, or Location of Death /4c. County of Death 4e Fecility Neme (If not institution, give street and number) Hospital Hopkins paltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) M Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Months Days 1□ M 2□ F 213-34-4631 61 Vis 05-06-37 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits x 1□ Yes 2□ No Baltimore 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? 906 McDonough Street 21205 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Merried 1 Yes ANO 1 Yes 2 No Specify: Specify: Black 3☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Laundry Elementery/Secondary (0-12) College (1-4or 5+) 5th Grade Presser Lord Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Tyson Jeannette Saunders 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205 turnage 906 McDonough Street Baltimore, Maryland Carolyn 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete MD 20e. Method of Disposition Date 1 Buriel 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) King Mem. Pk. Cemetery 01-22-99 Randallstown, 22. Name end Address of Facility 21. Signature of Puneral Service Licensee Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 254 Part. Enter the disease, or admplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Latronly one cause on wach line. Approximeta Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Brain 3 days Due to (or es a consequer Pulseless Activity 3 days Electrical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes an autopsy 1 Yes 2 No 1 ☐ Yes

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Jamary 17

29d. Date signed (Month, Day, Year)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. Stete

MD

**Funeral** 

Director

r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at

filed within 72 hours after

Hygiene.

permit. Pages 1 and 2 should be filed with Department of Health and Mental Physient Important: if item 27 is marked other that any Injury or other traumatic event, that once.

altimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

certificate this

Records, P.O. Box 68760,

Division of Vital

Physician/Medicai ģ Completed Be Certification: To Director

or Attending hours after death. To the Hospital or A within 24 hours after To the Funeral Directompletaly filled in by

**DHMH 16 Rev 6/95** 

State Registrar

edical

Todd Brudley Cler

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

5 Pending Investigation

6 Could not be determined

25. Wes cese referred to medicel exeminer?

29b. Signeture end title of certifier

odd Ellerin 31. Dete filed (Month, Day, Year)

1 Yes 2 No

27. Mannar of Death

Naturai

3 ☐ Suicide

4 Homicide

(Check only one)

600 North Wolfe Street Baltimore, Maryland Johns Hopkins Hospital 32. Registrer's Signeture

Hospital: 1 Inpatient

28e. Date of Injury (Month, Dey Year)

2 ER/Outpatient 3 DOA

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work?

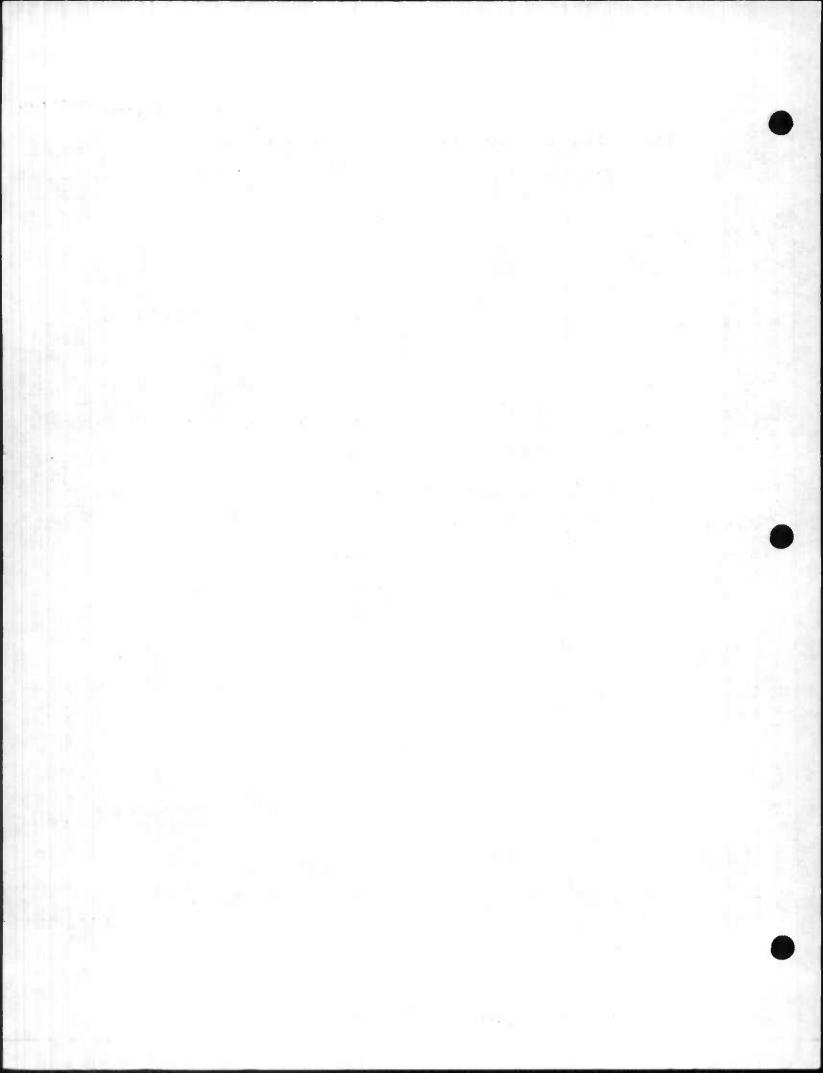
1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated.

29c. License number

1 Yes 2 No

RES -000

**ORIGINAL** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** Millian STOCKBRIDGE LRUZAN. JA anuary /Medical 4a Facility Neme (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number GENERAL HOSPITAL HARFORC If Under 1 Yeer 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days DEM 2DF Months Director 577 34 3670 2.a nordinteally Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehon 1 Yes 2 No Director PLABADA JOBILE . 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Norms 23a 36618 relooply CAO 1919 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Merried "natural", or 1 Yes 28 No Specify: Specify: WHILE by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry i Hygiene. ILIBOS 70 KT Elementery/Secondery (0-12) College (1-4or 5+) = OF Public .. Pages 1 and 2 should be filed wi tment of Health and Mentai Hygien tant: If Item 27 is marked other th jury or other traumatic event, the 127RS 3 YRS ALABAMA WORKS 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) VILLIAM S. ERUZ KOSSMARY FORTS NEX 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) H-CRUZAC KACHEL 1612 W0001 106,15, ALABAMA 36618 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State JAN. 18 permit. Page Department of Important: If any Injury or pace. □ Donation 5 □ Other (Specify) FORIST HILL 1 ARYLAND 1999 22. Nemie end Address of Facility EVANS FUNKAL CHAPIL - BILAIR 21 Signature of Euneral Service Licenses PA 02016 30 RWPORT DRIVE FOREST 1ARYLAM 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear fellure. List only one thuse on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Final LTure disease or conditto resulting in deeth) Examiner Due to (or es a consequence of) Examiner phenonen attending physician and for use as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): Physician/Medical thet initieted events resulting in death) Last Due to (or es a consequence of): Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PlaceMen p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed dentiele 1 Yes 2 No 25. Wes case referred to medical exeminer? 1 Yes 2 No Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Netural 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours at Funeral D letely filled 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 032295 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0020

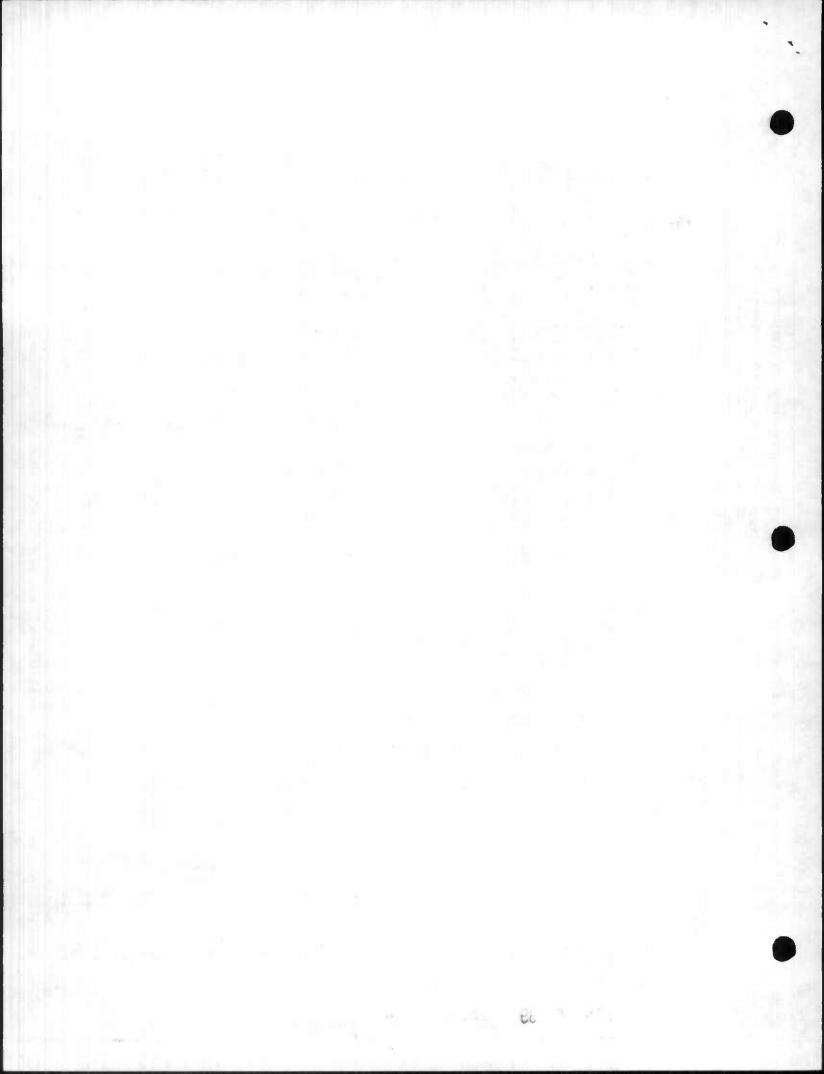
State Registrar

DHMH 16 Rav 6/95

31. Date filed (Month, Dey, Year) JAN 2 0 1999

32. Registrar's Signeture

6,5 We, T Mocha



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#7 per FH G767 1/29/99 EW 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Data of Death Month January 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death altimore If Undar 24 Hrs. If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 M 2□ F Ho Yrs. Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 010 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 ☑ Yas 2 ☐ No If Yes, Giva Yaar or Datas: WW∐ 1 Navar Married 2 Married 1 Yas 2 No Specify: White Specify: 3 Widowad 4 Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 18. Mothar's Nama (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) nda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stafe, Zip Code) 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20a. Mathod of Disposition Data 20c. Location City or Town, Stata 1 Surial 2 Cramation 3 Removal from Stata 4 Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signature of Punaral Sagvice Licanses Valled 21093 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of/dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death tmmediata Cause (Final disaase or condition rasulting tn daath) Dua to (or as a consequence of): Sequentially tist conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disease or Injury that initiated events rasulting In death) Last Due to (or as a consequence of): Dua to (or as a consaquanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No 1 Yas 1 ☐ Yas 2 No 26. Place of Death (Check only one) Hospitat: Othar: 4 ☐ Nursing Home 5 Residence 6 ☐ Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Natural
Accident 1 ☐ Yas 2 ☐ No

end I-transit The law requires that the death certificate be executed attending physician e for use as the buriel-Division of Vital Records, P.O. Box 68760, signed by the a cartificate hes b lirector, page 2 sl or Attending Physician: this funeral death. Director: A a 24 hours efter des re Funeral Director pletely filled in by th

Physician/Medical Examiner

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Completed

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Certification:

edicai

Physician

/Medical Examiner

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

Be

**Funeral** 

Director

with the Maryland

permit. Pagas 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Health and Mentel Hygiene.
Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avent, the Modical Examines must be notified as once.

Baltimore, Maryland 21215-0020

25. Was casa rafarrad to medicat axaminar? 1 Yas 2 No 27. Manner of Death

5 Panding invastigation

6 Could not be datarmined

28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify)

HANOUER

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar

3 Sulcida

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29 Signal

29c. Licansa numbar

29d. Data signed (Month, Day, Year)

MD

D38675

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es of person who completed cause of death (Itam 23a) (Type, Print) JOGL MESHUM

BALTIMORE MS

21230

State

Registrar

f (Month, Day, Year) JAN 2 0 1999



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**DHMH 16 Rev 6/95** 

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Please Type or Print in Black indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Items:16a,b per F.H G-767 1/20/99 reb Reg. No. edent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Death Month 12:04 PM 01 orothy 18 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Hospital of Baltmore | Hunder 1 Year 5. Sociel Security Number the If Under 24 Hrs. 8. Dete of Birth (Month, Pey, Year) BAltomore City Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Months Deys 1 M 2 F 254-52478 Georgia 02/37 3 Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Nes 2 No Ma timose 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1435 21238 5. WINSTON 11 verue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubay, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, 11. Maritel Status 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Detes: If Yes, specify Cuba Black, White, etc. 1 Never Merried 2 Married 1□ Yes 21 No Specify. 3 Widowed 4 □ Divorced lack 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) B.W.I Elementary/Secondary (0-12) College (1-4or 5+) Security Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) obert Thnie . Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2403 Queens C

20b. Place of Disposition (Name of cametery, cremetory or other place) Settimon 14.

20c. Location - City or Town, State HAtTONL 20a. Method of Disposition Date 1 Burial 2 Cremetion 3 Removal from State Noting 4 ☐ Donetion 5 ☐ Other (Specify) Marulera Memorie 21. Signeture of Fundral Service Licenses 22. Name end Address of Fecility unertal home +Services North 1639 ner heldisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest heart ailure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) Due to (or es a consequence of) D Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of ceuse of death? 24e. Was en eutopsy 2 DIN 1 Yes 2 No 1 Yes 1ATEd Diannyo 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Pinpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menney of Deeth 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending 1 Yes 2 🗆 No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

/Medical Examiner requires that the death certificate be executed and ettending physician ed by the e s been signed by the should be detech-The law hes this certificate Division of Vital Hospital or Attending Physician: 24 hours effer death. Funeral Director: After this certifice funeral director, To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: All completely filled in by the fu

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

29e. Certifier

30 Name

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar mast be notified at

Important: If item 27 is marked other transmitted any injury or other traumatic event, the Market Once.

Pages 1 and 2 should be in nent of Health end Mentel

permit. Page Department

**Physician** 

the Marylend

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death

72 hours efter

filed within

Baltimore, Maryland 21215-0020

State Registrar

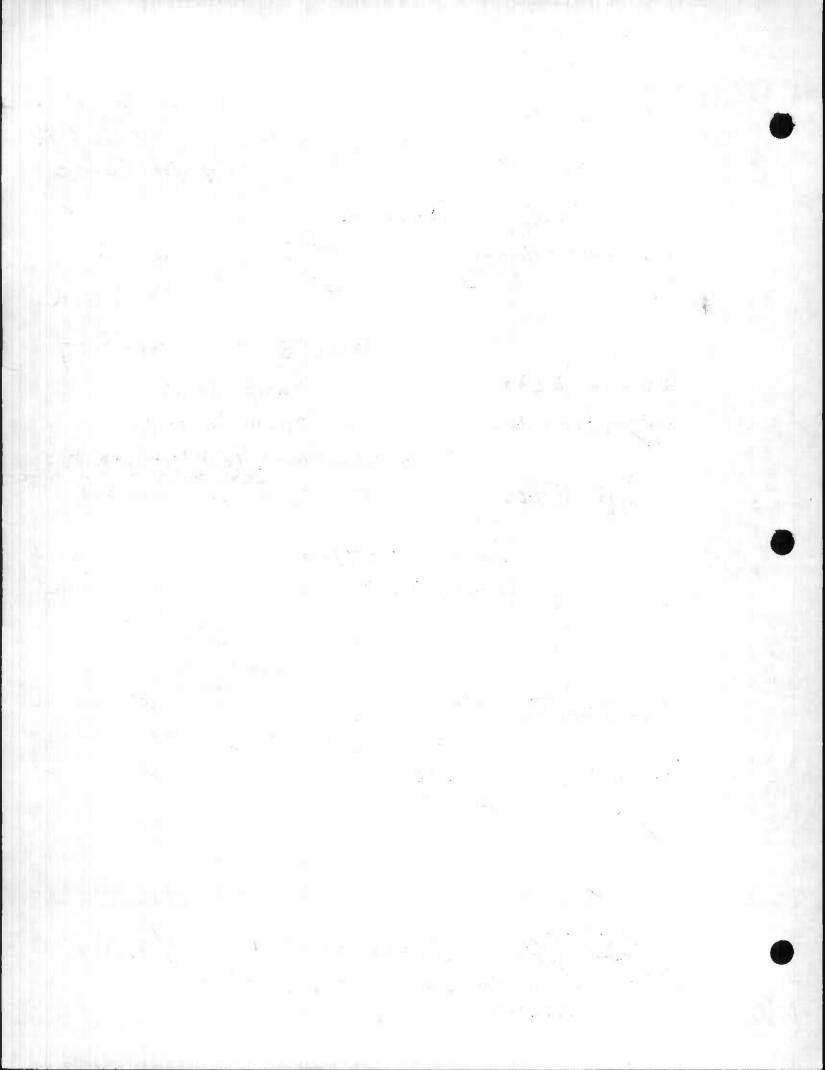
-oberta cest 31. Date filed (Month, Dey, Year) 32. Registra 1999

29b Signature and title of certifier

end address of pe

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and piace, and due to the cause(s) end menner stated. 29d. Date signed (Month. Day, Year)



1. Decedent's Name (First, Middle, Last)

W

4a Facility Neme (If not institution, give street end number)

NORMAN

**Physician** 

/Medical

**Examiner** 

Sinai Hospital of Baltimore If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) 7-9-1937 Birthplece (State or Foreign County) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 1□**X**M 2□ F Months Deys Hours 244-52-2229 61 Yrs. **Director** Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or itams 23s or 28s-1 show other traumetic event, the Modical Examiner must be notified at 1 Yes 2 No N/A Directo RANDALSTOWN 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 9819 TOLWORTH CIRCLE U.S.A. 21133 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 💢 Married 1 Yes 2 No Specify Specify: AFR. AMERICAN ò 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry OWNER OPERATOR TAXI CAB and Mental Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED 0 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) ould be CICERO LENNON LILLIE ANDERS 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) permit. Peges 1 end 2
Department of Health as Important: If Item 27 Is any Injury or other trau NANCY LENNON (WIFE) 9819 TOLWORTH CIRCLE RANDALSTOWN MD 21133 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Deuriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) KING MEM. PARK JAN. 20,1999 RANDALSTOWN MD 21. Signature of Funeral Service Ligensee EUGENE, N WALKER 22. Name end Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 23a. Part1. Enforthe disease, or complications that caus shock at heart failure. List only one cause on each 1300 EUTÂW PLACE BALTIMORE MD 21217 Approximate Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical 6 Days Severe Anoxia Encephalopathy Examiner Due to (or es e consequence ot) Examiner 6 Wks MRSA Sepsis attending physician and for use es the burial-tran Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): death certificate be Physician/Medical Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. the th signed by t 1 Yee 2 No 3 Probably Wunknown Lymphoma, S/P Girdle Stone P Division of Vital Records. 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? To R Hip has page 2 1 Yes 2 No 2 9 No 1 ☐ Yes certificate or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No P 1 Unpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: After 5 Pending investigation 1 Naturei er death. 1 ☐ Yes 2 ☐ No 2 Accident 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Sulcide 3 4 ☐ Homicide after Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

William Krimsky 31. Date filed (Month, Day, Year)

JAN 2 0 1999

State Registrar

**DHMH 16 Rev 6/95** 

2401 W. Belvedere Ave

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Dete of Deeth

15

1999

N/A

January 15, 1999

Baltimore, MD 21215

4c. County of Deeth

Month

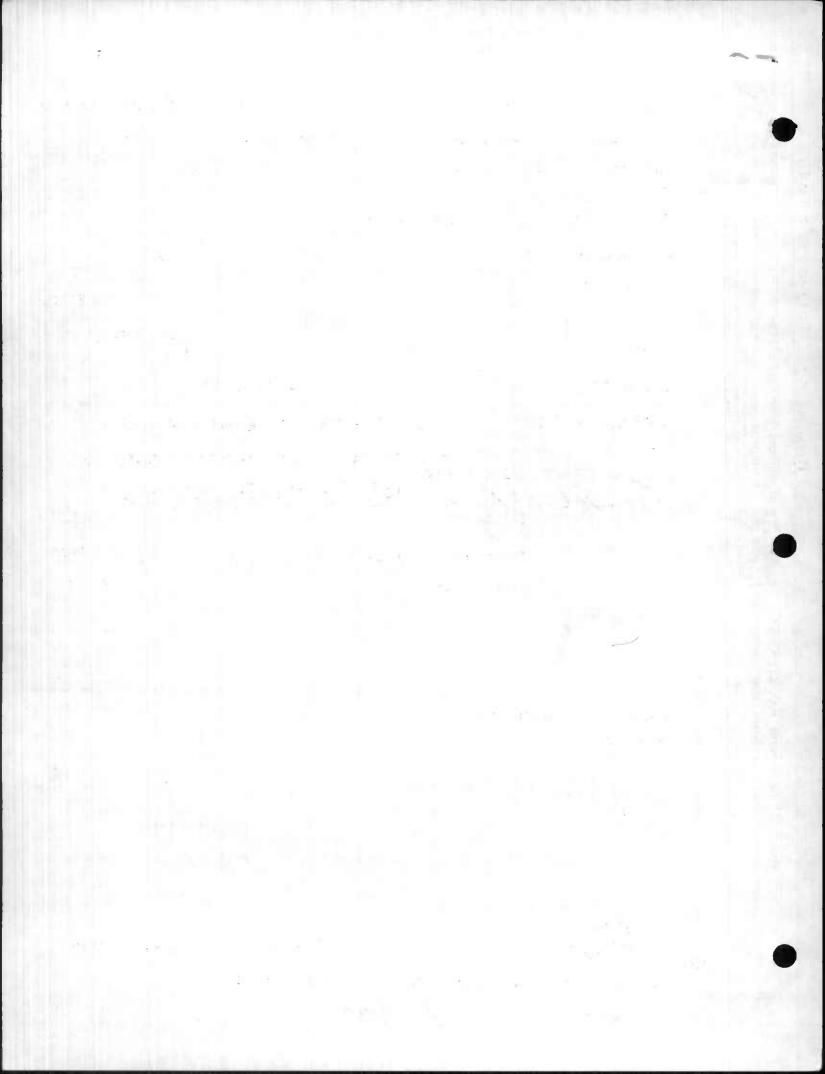
4b. City, Town, or Location of Death

Baltimore

January

3. Time of Death

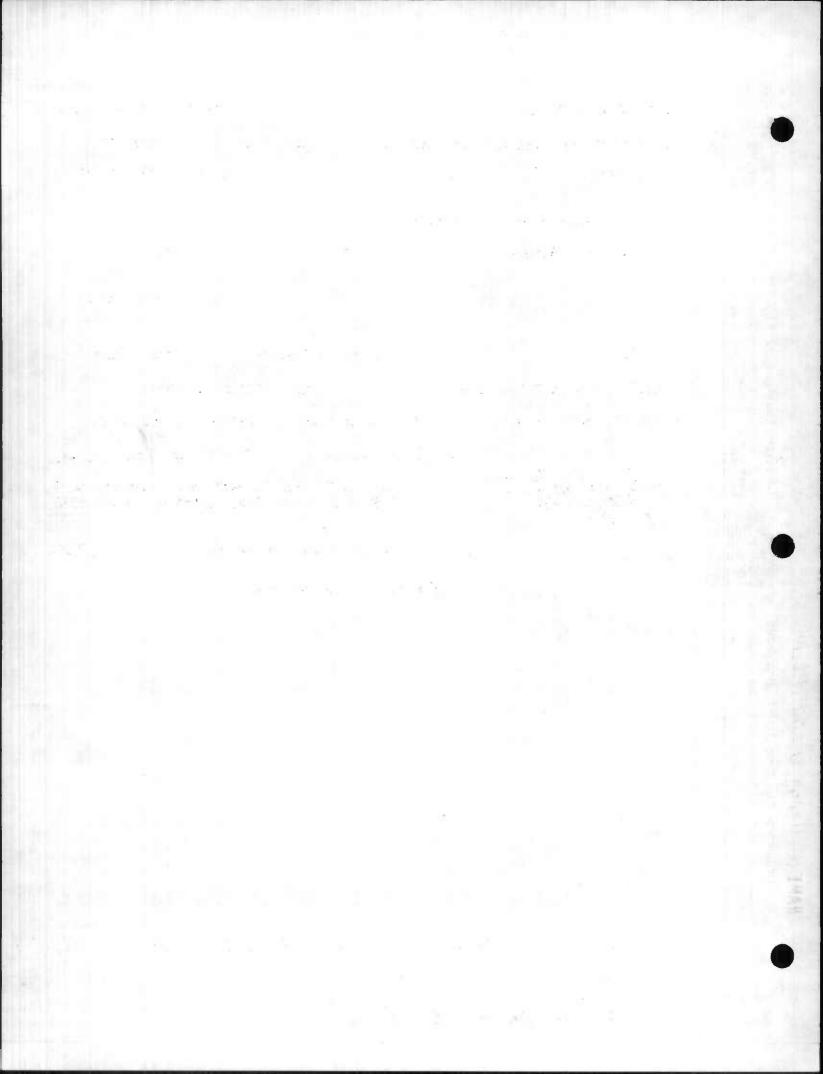
9:15 am



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Deta of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) Day Yaar **Physician** WILLIAM O'LOUGHLIN JANUARY 16, 1999 0455 AM /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SAINT AGNES HOSPITAL 900 CATON AVENUE BALTIMORE BALTIMORE If Under 24 Hrs. Hours Min. Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days 79 **Director** JAN. 14, 1920 218-14-6055 Maryland Usual Residanca of Decedan the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow notified at 1 Yas 2 No Director MD Baltimore Arbutus 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 7 is marked other than "natural", or items 23s or traumstic event, the Medical Examiner must be 121 Waelchli Avenue 21227 USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Haelth end Mental Hygiane. Importment if item 27 Is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Execution man Funeral 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 🖾 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Electronics Tester Bendix Corp. 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Be William Edward O'Loughlin Edith Elizabeth Chaney 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Doris O'Loughlin - wife 121 Waelchli Avenue, Baltimore, Md. 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other pleca) Dale 20c. Location - City or Town, State 1/19/99 1 Burlal 2 Cremation 3 Removal from State 4 Donation 5 Othar (Specify) Cedar Hill Cemetery Glen Burnie, Md. 22. Nama and Addrass of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. Enter the discusse, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Daath Physician ASPIRATION PNEUMON in /Medical Immediata Causa (Final disaasa or condition resulting in death) 2 hours Examiner Dua to (or as a consequanca of): Physician/Medical Examiner BRAIN physician end the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that Initiated avants rasulting in daath) Last Dua to (or as a consequence of) Due to (or as a consequance of) NAME WilliAM O'LOUGHLIN usa as t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown by 24b. Wera autopsy findings available prior to completion of causa of deeth? Completed 24a. Wes an autopsy performed? cartificate hes b 1 Yas 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Rasidance 8 Othar (Specify) 1 Yas 2 No 2 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 5 Panding invastigation Netural 1 Yas 2 No 2 Accident 6 Could not be datermined 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 3 ☐ Sulcide 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 | Homicida A 24 hou. 1 Certifying Physician: To the best of my knowledga, death occurred et the time, dete end placa, and dua to tha causa(s) and menner es stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune complately fi 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier DOUS1865 JANUARY 30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print) About HUSPITM BAZTIMORE MARUS CURTES 31. Dete filed (Month, Dey, Year) 32. Registrar's Signatura State JAN 2 0 1999

**DHMH 16 Rev 6/95** 

Registrar



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					Certifi	cate of	Death		Reg. No.		J U I	
Physician		1. Decedent's Name (First, Middle, La.	st)					2. Dete of De Month	Dey	Year	3. Time of Death	
/Medica			Ethel	ys Liebr	10		January	7 14, 19	999	1:24a.m.		
Examine		4e Facility Name (If not institution, giv-			4b. City, Town, or	Location of Death	4c. County	of Death				
		Augsburg Lutheran Home Loche							Balt	timore		
Funeral Director		217-05-5123	ex	ge (In yrs. 89		under 1 Year onths Days		(Month, Da	y, Year) 0, 1909	9. Birthplac Country Mary	ca (Stete or Foreigr ) Land	
b *	-	Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Locatio	0				100	d. Inside City Limits	
e Maryla	Director	Maryland Howard		100. 01	y, Town of Locatio		cott City				1 ☐ Yes 2X No	
# 82 P	<u>e</u>	10e. Street and Number 10f. Zip Code							10g. Citizen of What Country?			
23a	<u>a</u>	2370 Daniels Road	l				21043		United	States	S	
72 hours efter deeth with the Maryland "natural", or frems 23s or 28s-f show odical Examinet must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☼ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 Yes 2 13 If Yes, Give Year or Dates:	?		Decedent of specify Cut	Hispanic Origin? (S ben, Mexican, Puert Specify:	pecify Yea or No o Rican, etc.)	Blad	ce - Americer ck, White, etc y: White	c.	
2 ho	2	15. Decedent's Ed			16a. Decedent's	Usual Occu	pation		16b. Kind of B	uainess/indu	stry	
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Hygie de La La La La La La La La La La La La La	Š -	17. Father's Name (First, Middle, Last)			пошешат		18. Mother's Nar	na (First, Middle,				
Mental Mental	Be		lilliam	Kirk				a Elizal				
should ind Men marke umatic	၉	19a. Informant's Name/Ralationship (		KILK	10b Malting A	Idraeo /Circo	t end Number or Ru				(ode)	
		Robert Liebno	יאריי יישליי		2370 Da		Road					
	-	20a. Method of Disposition		20b. P	Plece of Disposition	(Neme of	EII	icott C:	20c. Location			
Page hant or uny or		1 ☑ Burlal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		C	emetery, cremetor	y or other ple	ry Januar					
permit. Depart Import any inj	Depart Depart Import any inj ance	21. Signature of Funeral Service Licensee  22. Name end Address of Facility Loring Byers Funeral Directors, Inc										
_		8728 Liberty Rd. Randallstown,								D 21133-4784 Approximete		
1		23a Pant Enter the grease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, show, or heart failure. List only one cause on each line.								Interval Between Onset end Deeth		
Physician /Medical Examiner	16	Immediate Cause (Final disease or condition resulting in death)	TERMIN		OVARIA or as a consequence		ARCINOM	A		4	months	
pet nsit	Examiner		b									
cete be executed physician end sthe buriel-transit	Xal	Sequentially list conditions, if any, leading to immediata causa. Enter Undarlying Causa (Disaasa or Injury		Due to (o	to (or as a consequance of):							
ficete be explored by physician as the burie	62	Causa (Disaasa or Injury	c									
5 O a	edical	that initiated avants pue to (or as a consequence of): resulting in deeth) Last										
ath cert for use	2		d							1		
death cei	000	Part II. Other significant conditions of	ontributing to death t	out not ras	ulting in the under	vina ceuse a	iven in Part I.	23b. Dld	tobacco use co	ontribute to t	the cause of death?	
	Phys					,		10	Yes 2 No	3 Probe	bly 4 Onknow	
0 8 5 6 .	Completed by								an autopsy ermed?	com	e autopsy findings lable prior to pletion of ceuse	
The law ate has be page 2 s	E E										eath?	
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hys hys	2	1 Yes 21 No	Hospital: 1 Inpati			LI DOA		fome 5 ☐ Resi		-		
Attending Port death.  Soctor: After the by the funera	Certification:	27. Manger of Death  1 Matural 5 Pending 2 Accident Investigation		ury By Year)	28b. Time of Injury	28c. Inju	ury at ork? ] Yes 2 □ No		how injury occur			
DIVISION  Let or Attending  Is after death.  In Director: After  ed in by the fune	Certifle	3 Sulcide 6 Could not be determined	ome, farm, street, t	actory, office		28f. Location ( City or To	Street and Numi wn, Stete)	ber or Rural i	Route Number,			
	edical	29a. Certifier (Check only one)	ysician: To the best niner: On the basis of and manner st	of axamina	wledga, daath occ tion and/or Invasti	urred at tha t gation, in my	ima, data and place opinion, daath occu	a, and dua to the urred at the time,	causa(s) and m data and place,	enner as stat , and dua to t	led. he causa(s)	
vithir outh	Me	29b. Signature and title of cartifier	)			29c. Licen	se number		29d. Date signe	ed (Month, De	ay, Year)	
F 5 F 0		The second secon	ierce 80			H45	5931		Januar	Y 15,	1999	
		30. Nama and addrass of person who Dobovah I. PIGN	complated causa of	0	23a) (Type, Print 20 PAR	UL ITE	GHTS AVE	ENUE	BALTIN	NORE.	MD 2120	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** B. LEVY **JEANNETTE** 6:50 PM **JANUARY** 13, 1999 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner 500 W. UNIVERSITY PKWY. #4C BALTIMORE N/A If Undar 1 Yeer | If Under 24 Hrs. Birthplace (Stata or Foraign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Months Hours 10 M 20 F FEB. 15, Director 94 MD 217-46-0792 Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits **show** MD N/A BALTIMORE 1X Yas 2 No Director 258-1 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 'natural', or flams 23s or must be. 500 W. UNIVERSITY PKWY. #4C 21210 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 1 Never Merried 2 Merried WHITE Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à XX Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 about be filled w Department of Health and Mental Hygen Important: If then 27 is marked other that any Injury or other transmissed other that 5+ HOMEMAKER OWN HOME 17. Fathar's Nema (First, Middla, Last) 18. Mother's Neme (First, Middla, Maiden Sumama) Be PHILIP BLUM ANNIE GOLDSTEIN 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 86 OAK CREEK TRAIL - MADISON, WI JAY LEVY / SON 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1XX Burial 2 Cremetion 3 Ramovel from Steta BALTIMORE HEBREW CEMETERY 1/14/99 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signature of Funaral Sarvice Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 23e. Pert1. Entar tha disaasa, or complications that caused the deeth. Do not anter tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only ona ceuse on each line. Approximata Intarval Batween Onset and Death **Physician** Immediata Causa (Final disaese or condition resulting in death) /Medical corduc arrest Examiner Dua to (or as a consequance of): Examiner metabolic imbelonce Sequantielly list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or injury that initiated avents resulting in daath) Last Due to (or as a consequence of): physician Box 68760 rend inscsfi arene Physician/Medical the Dua to (or as a consequence of): 98 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 3 Probably 4 Unknown signed by 1 Yes 2 No p 24b. Were eutopsy tindings eveilable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed Deed has page 2 2000 1 Yes 2 No 1 Yas certificate Physician: 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After 5 ☐ Pending 1 TYas 2 No invastigation 2 Accidant 6 Could not be datarmined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 3 4 Homicida 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the tima, deta and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, deta and place, end due to the cause(s) and manner stated. edical 29a. Cartifier npletely (Check only one) 290. Signature and time of certific 29c. License number 29d. Data signed (Month, Day, Year) 019914 30. Name and add completed cause of death (Item 23a) (Type, Print)

Registrar

State

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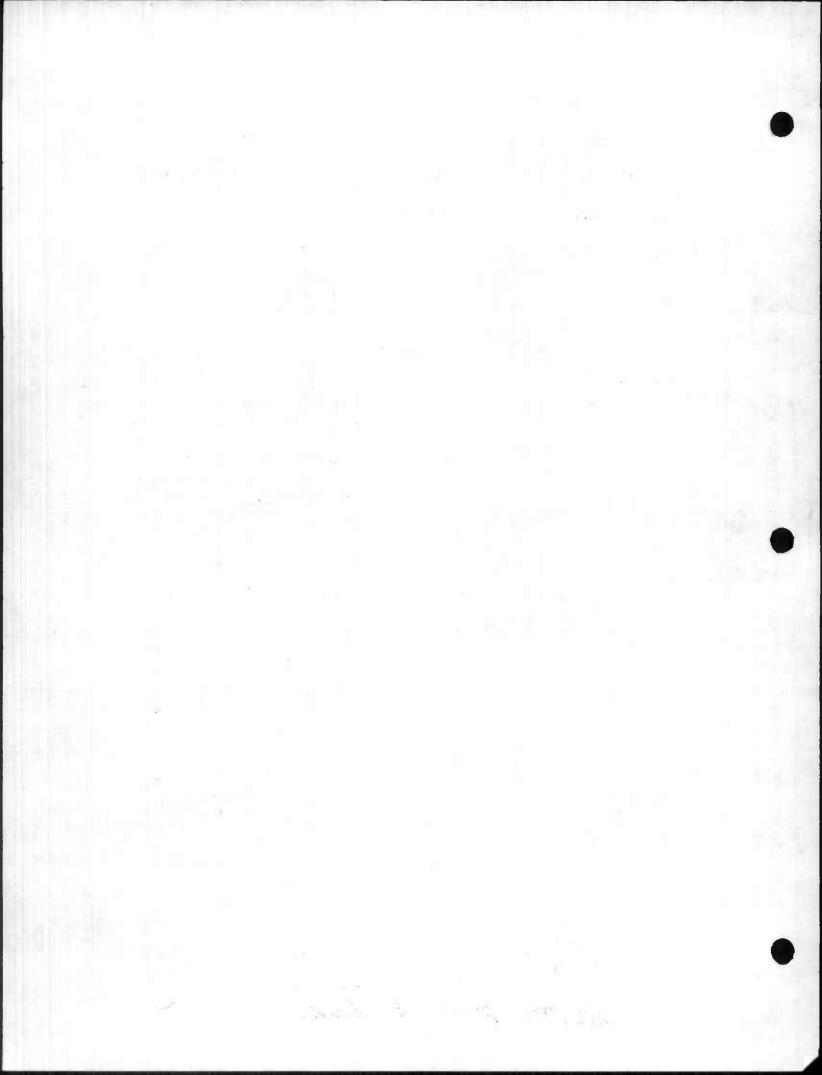
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31. Data filed (Month, Day, Year)

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32. Registrar's Signatura

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 4c Per PHY Film G767 1-19-99 rja Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Tima of Death Month Day **Physician** January 2, Minnie Rae Lacey 1999 3:55 p.m. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5406 Hillrise Road Glen Arm Baltimore Co. If Under 1 Year If Undar 24 Hrs.
Months Days Hours Min. Birthplaca (State or Foraign Country) 5 Social Security Number 8. Deta of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 KF Director 216-28-3958 April 27,1913 Baltimore, Maryland Usual Rasidance of Decedan the Marylend 10d Inside City Limits 10a Stata 10h County 10c City Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Magical Examines must be notified at 1 ☐ Yas 2 💢 No Director Maryland Baltimore Glen Arm 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 5406 Hillrise Road U.S.A. Funeral 21057 death 13. Was Decedant of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuben, Maxican, Puarto Rican, etc.) 11 Maritei Status 12. Wes Dacedent Evar in U.S. Armed Forcas?

1 Yas 2 No
If Yes, Giva
Year or Datas: Biack, Whita, atc 72 hours efter 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify: Specify à 3 Ø Widowed 4 □ Divorced White Completed 16a. Decedant's Usuel Occupation 16b. Kind of Businass/Industry 15. Dacadant's Education (Spacify only highest grada complated) (Giva kind of work dona during most of working lifa. DO NOT usa retired) filed within 7 Hygiene. Collega (1-4or 5+) Elamantery/Secondary (0-12) 12 yrs. Bookkeeper Koppers Company 18. Mother's Nama (First, Middla, Maiden Sumama) permit. Pages 1 end 2 should be file Department of Health end Mentel Hy Important: If flem 27 is marked other any Injury or other traumetic event PARS. 17. Father's Nama (First, Middla, Last) George Plantholdt Minnie Schroeder 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. informant's Name/Ratationship (Type, Print) Albert Lacey, Jr. 5406 Hillrise Road Glen Arm, Maryland 21057 (Son) Baltimore, 20b. Place of Disposition (Nama of cematary, crametory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 1/5/99 Baltimore, Maryland Meadowridge Memorial Pk. 22. Nama and Addrass of Facility E.F. Lassahn Funeral Home, P.A. 21. Signeture of Funeral Survices in 11750 Belair Road Kingsville, Maryland 21087-135 23a. Part1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Limit only one cause on each line. Approximeta Intervel Between Onset and Death **Physician** /Medical Immediata Causa (Final Disease Alzheimer's disaasa or condition rasulting in death) Examiner Dua to (or as a consequanca of) Examiner Phrumonia that the deeth certificete be executed physician and the burial-tran Sequantially list conditions, if any, leeding to immadiata cause. Enter Undarlying Cause (Disease or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): for use es signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the causs of death? O 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. P 24b. Ware eutopsy findings evailable prior to completion of cause of death? Completed 24a. Was en autopsy peen : a w hes 16 2 page The 1 Yas 1 Yas 2 No certificate Attending Physician: funeral director, Be 25. Was casa rafarrad to medical axaminar? 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 1 Yas 2 No 2 this 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28a. Data of Injury (Month, Day Year) 28b. Tima of After 5 Panding invastigation 1 M Neturei To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At home, farm, streat, fectory, offica building, etc. (Specify) 4 Homicide Certifying Physician: To tha best of my knowledge, deeth occurred et the time, deta and place, end due to tha causa(s) and menner es stated.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. edicai 29a, Certifian 29d. Data signed (Month, Day, Year) 29b. Signeture end title of 29c. Licansa number

State Registrar 31. Date filed (Month, Day, Year) JAN 2 0 1999

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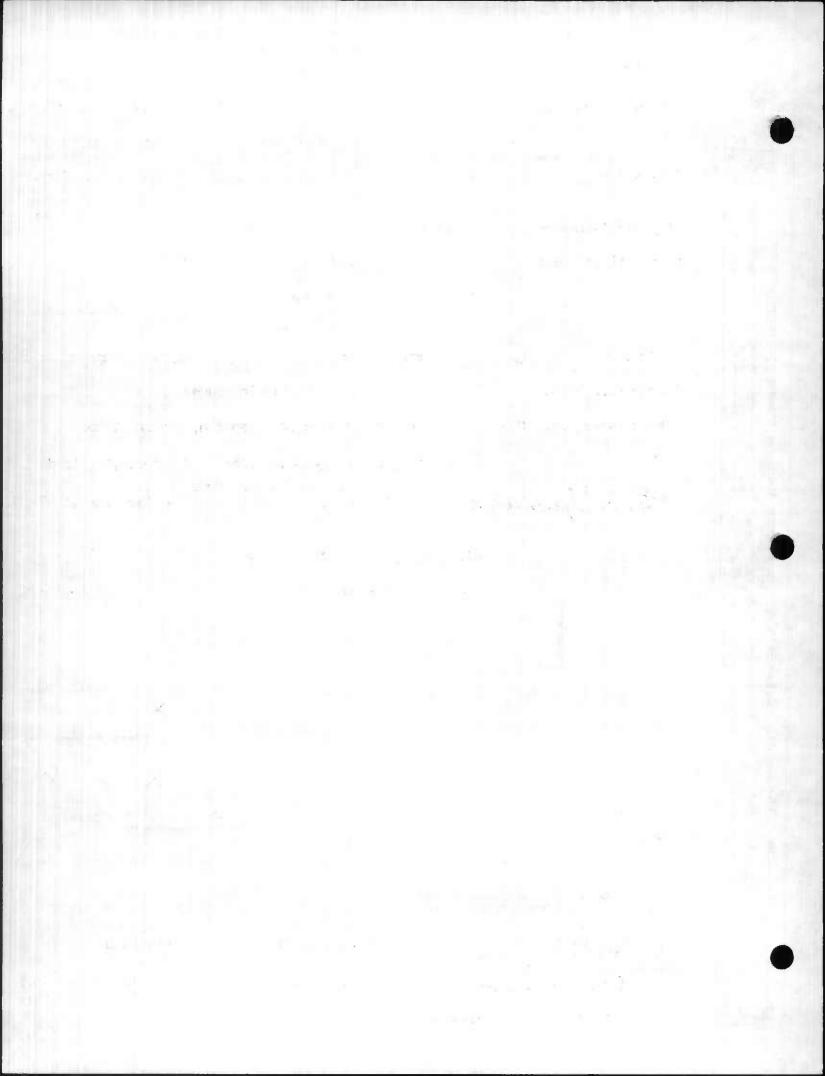
30. Nama and addrass of parson who completed cause of death (Item 23a) (Typa, Print)

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altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

Registrar

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30. Nama and addrass of person who completed ceuse of death (Item 23a) (Type, PMI) 31. Date tiled (Month, Day, Year)

32. Registrar's Signature

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DENNIA DELLAS LERGONE LA LA CONTRACTORA TWO IS TO BE READ IN THE RESIDENCE OF SECURITY OF SECURITY OF SECURITY OF SECURITY .91.346 LIP CONTRACTOR OF THE PARTY OF Bull 1915, and the same and the same and the same of t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year MILLER DONALP 13, 1999 02:10 PM DANUARY 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth JOHNS HOPKINS HOSPITAL SALTIMORE N/A If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Bay, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthpiace (State or Foreign Country) Days Months 1X M 2 F Yrs. 215-18-2854 76 July 4,1922 Maryland Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. Stete 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 607 Goodman Ave. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Stetus Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 20 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White WWII 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Veterans Elementery/Secondary (0-12) College (1-4or 5+) Administration Years Reality Specialist 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) August G. Miller Velma L. Phelps 19a. Informent's Neme/Reletionship (Type, Print) Wife 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Caroline B. Miller 607 Goodman Ave. Dundalk, Maryland 21222 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete PBuriel 2 ☐ Cremation 3 ☐ Removal from Stete ownsville V.A. Cem. 1/19/1999 Crownsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fundati Service Liceds 22. Name end Address of Fecility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part. Enter the disease, or complications thet caused the meth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximete tntervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Drongry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Due to (or es a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown stage reral 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes mon 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending Investigation

1 Yea 2 No

To Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner steted.

29c. License number

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event

after

Baltimore, Maryland 21215-0020

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Examine physician and s the burief-transit Physician/Medical g Completed Be 2 edical Certification:

Box 68760. certificate be P.O. Records, of Vital this After Division or Attending s effer death.

I Director: Aft din by the fur To the Hospital o within 24 hours of To the Funeral Di completely filled it

State Registrar

SMITH 31. Date filed (Month, Day, Year) JAN 1 9 1999

29b. Signature and title of certifier

6 ☐ Could not be

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) 110 TOWER

730 Rottand Are Bultmore, MD 21287 MOOST 32. Registrer's Signeture

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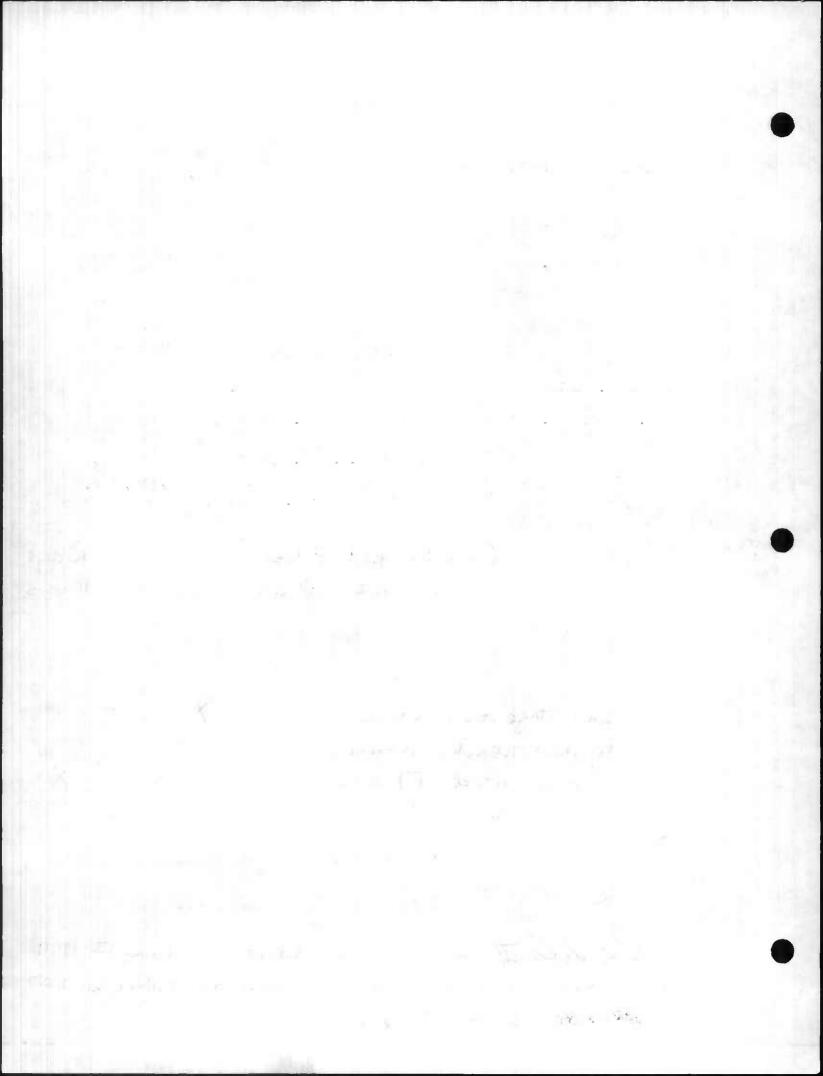
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

**DHMH 16 Rav 6/95** 

3 Suicide

29e. Cartifier (Check only one)

4 Homicide



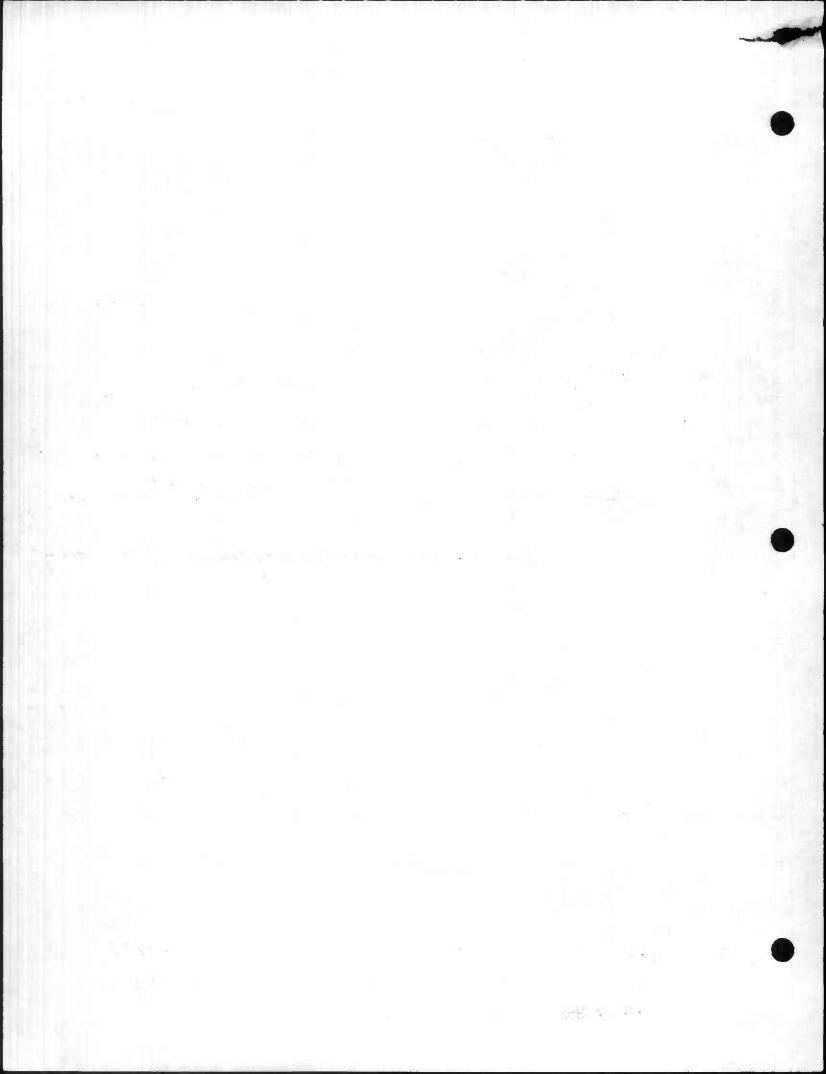
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State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 16, 12:45 PM Katherine Assunta Marani /Medical 4a Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Genesis Eldercare-Cromwell Center Baynesville If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 8. Dete of Birth 08-08-1906 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 20 F Months Marviand 220-03-4210 92 Director Usual Residence of Decedent 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene.
Important: If its marked other than "natural", or itema 23a or 28a-f ahow any Injury or other traumatic avant, the Medical Exaginet matter mounted at page. 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. 8701 Maravoss Lane Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Bleck, Whita, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carmela Perella Giovanni Terzano 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 8700 Maravoss Lane Baltimore, Maryland Dr. S. Donald Marani 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 1-20-99 Moreland Memorial Park Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licenses J. Wayne Osterling 5305 Harford Road Baltimore, Maryland 21214 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, in failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical Arferioxlestic Comorgantery disease onex Examiner Examiner the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted evente resulting in death) Last and Due to (or as a consequence of) attending physician Box 68760 Physician/Medical Due to (or as a consequence of) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 € Unknown Division of Vitai Records. by 24b. Were autopsy tindings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 400 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? To the Hospital or Attanding Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funera Certification: After 1 KNeturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or Investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D21022 and address of person who completed cause of death (Item 23a) (Type, Print) 8114 SANDPIPER CIRCLE MON MOZIZIG 1. KOWA LOUSICI MD 32. Registrer'e Signeture State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death January 8, 1999 **Physician** 5:20pm Jerome T. Maher /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Eldercare - Homewood Center N/A Towson 8. Data of Birth (Month, Day, Year) March 1, 1921 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral ₩** M 2□ F Days Hours Months 217-16-8073 Maryland Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at the Maryte 1 XYes 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? hems 23s or 4108 Century Road 21206 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1X□ Yes 2□ No
If Yes, Give
Year or Datas: WWII 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status r then "natural", or her the Medical Examiner 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important; if hear 27 is marked other th any Injury or other from 11 Machinery Operator Western Electric 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Frank Maher Mamie Westerfeld 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Maher / Wife Same as item 10e. 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/12/99 Gardens of Faith Cem. Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cerebrovascular Accident 4+ Years Examiner Due to (or es e consequence of): Examiner sician and burial-transit be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical Due to (or as a consequence of) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 : certificate has 1 ☐ Yes 2 X No 1 ☐ Yes 2 X No Division of Vital 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 10 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending investigation 1 K Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

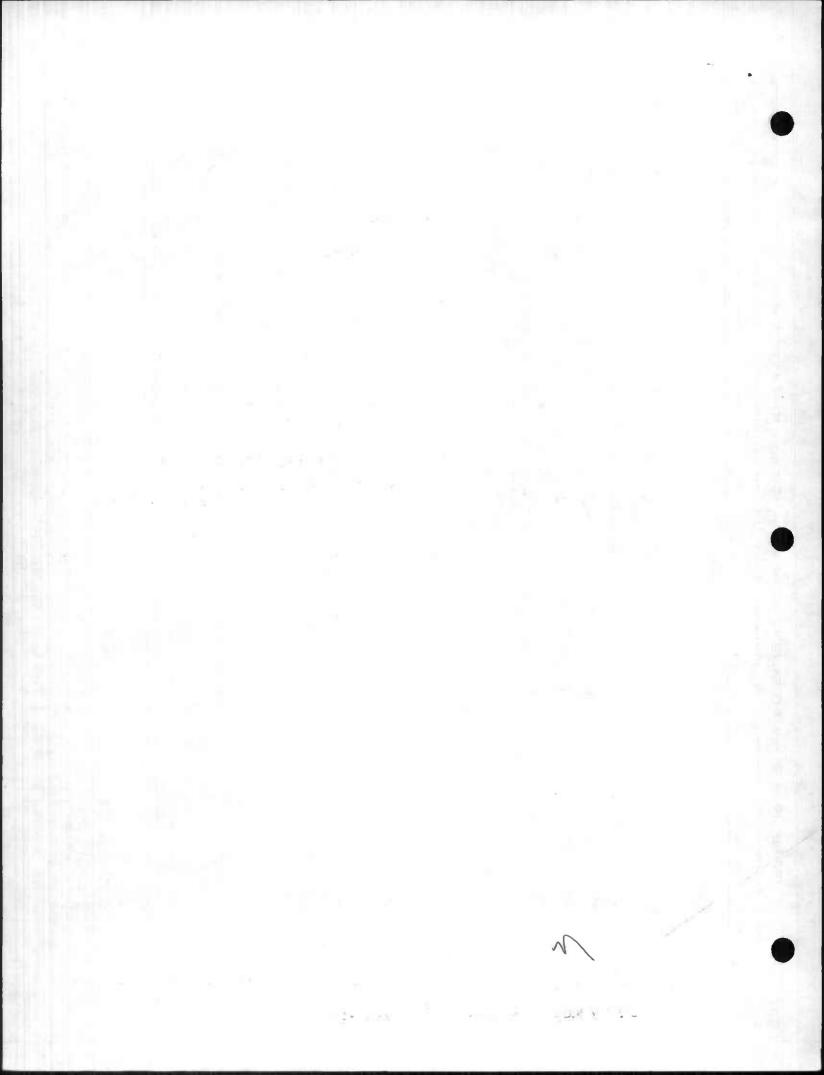
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and fitle of cartifier 29c. License number 29d. Date signed (Month, Day, Year) Mien Kir D31865 30. Name and address of parson who completed cause of death (tem 23a) (Type, Print) Dr. Mien Kioune, 821 N. Eutaw Street Rm. 206 Baltimore, Maryland 21201 31. Date filed (Month, Dey, Year) 32. Registrar's Signature

**DHMH 16 Rev 6/95** 

State

Registrar

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**Physician** /Medical Examiner Box 68760.

Physician/Medical Examiner

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**Physician** 

/Medical

Examiner

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7 is marked other than "natural", or frame 23a or 28a-f show traumatic event, tre Wedscal Examinar mant by notified at

Hygiene.

permit. Peges 1 end 2 should be filled wh Department of Health and Mentel Physiera Important: If item 27 is marked other tha any injury or other traumatic event, that

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filed within 72 hours efter death with

Baltimore, Maryland 21215-0020

that the death certificate by any signed by the a lew requires peen hes The is certificate h Physician: this funeral After or Attending bliector: A in by the fe r death.

Division of Vital Records, P.O.

To the Hospital within 24 hours To the Funeral

25. Was case rafarrad to medical axaminar? 1 Yes 2 → Yo 28a. Date of fnjury (Month, Day Year) 27. Mannar of Death 1 Naturei 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 8 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, streat, factory, office building, etc. (Specify) 4 Homicida 29a. Certifier 1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and placa, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tale of the 29c. License number AHENDINA

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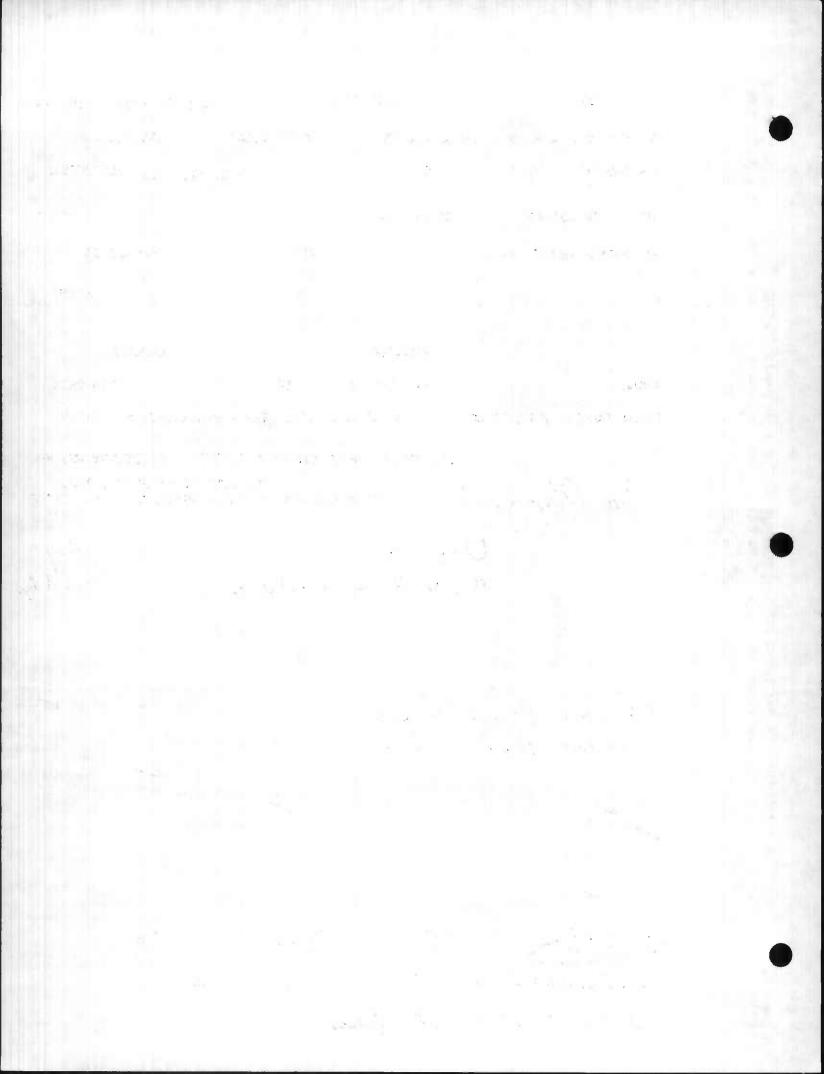
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31. Date filed (Month, Day, Year)

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32. Registrar's Signature



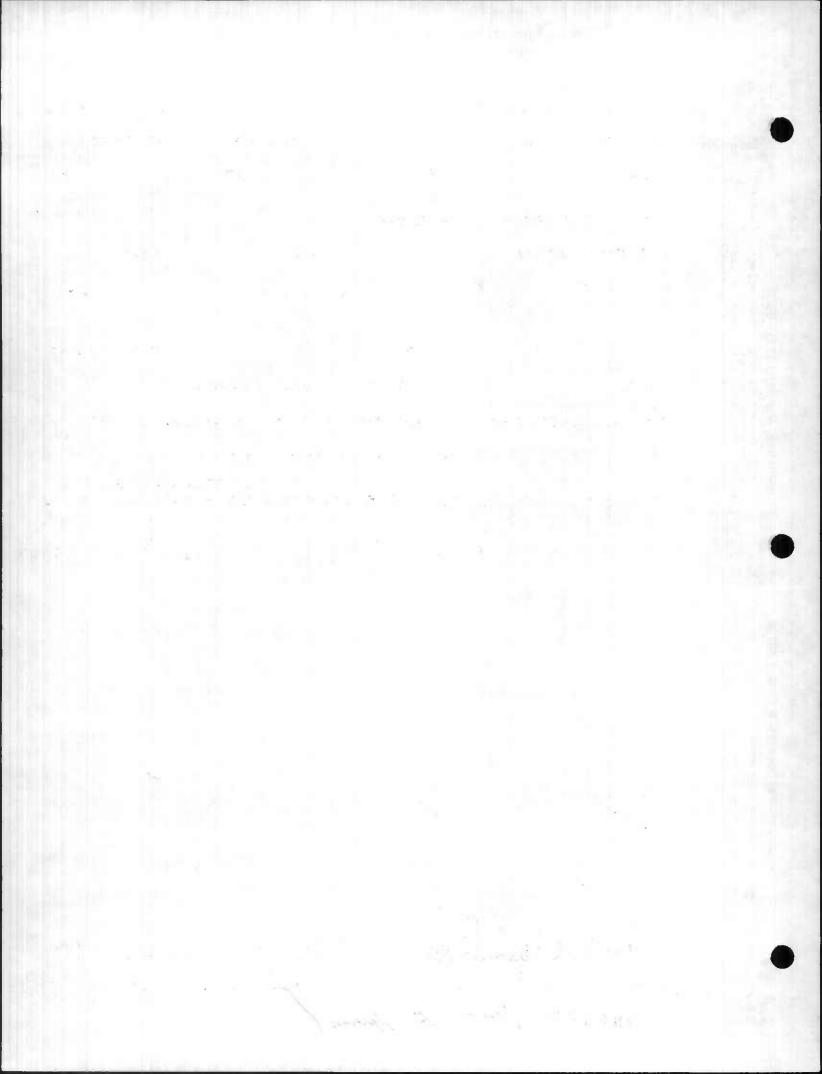
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Daath 3. Tima of Death Month Dav Yaer **Physician** 4a Facility Nama (If not institution, giva street and number) 4c. County of Death January /Medical 4b. City, Town, or Location of Deeth Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Yeer If Undar 24 Hrs. 5. Social Sacurity Number 6. Sex Birthplaca (Stata or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Deta of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 1 F Days Hours Yrs. **Director** 64 176-26-9939 JUNE 9,1934 Usual Residance of Decedant the Manyland 10a. Steta 10b. County 10c. City. Town or Location worle 10d, insida City Limits 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examiner, must be notified at 1 ☐ Yas 2 No Directo MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zlp Coda 10g. Citizen of What Country? 6659 SANZO ROAD 21209 #E U.S.A. Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: if them 27 is marked other than any injury or other traum. 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yas 22 No If Yes, Giva Year or Datas: 14 Race - American Indian. 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Ricen, atc.) Black, White, etc. 1 Never Merried 2 Married WHITE 1 ☐ Yas 2 No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working iifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) Collega (1-4or 5+) OWNER BAKERY EQUIPMENT 17. Fether's Neme (First, Middla, Last) 18. Mothar's Neme (First, Middla, Meiden Surneme) DAVID WEINER MENNA WEINSTOCK 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) IRWIN J. MATHASON / HUSBAND 6659 SANZO ROAD #E - BALTIMORE, MD 21209 20b. Place of Disposition (Nama of cemetery, crametory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 X Buriel 2 ☐ Cremetion 3 ☐ Ramoval from Stata DRUID RIDGE CEMETERY 1/18/99 PIKESVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Fecility 21. Signatura of Funaral Sarvice Licensae SOL LEVINSON & BROS., INC. Socie 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediata Ceusa (Finel disaasa or condition rasulting In daath) 8m% 160) Examiner Due to (or as a consequence of) Examine Sequantielly list conditions, if any, laading to immadiate ceusa. Enter Underlying Causa (Disaasa or Injury that initiated avents resulting in daeth) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequance of): # 957 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 2 à 1 Ses 2 No 3 Probably 4 Unknown À 24b. Wara autopsy findings availabla prior to completion of ceuse of daeth? 24a. Was an autopsy Completed performed? D808 2 certificate has 1 🗆 Yas 2500 1 ☐ Yas 2 ☐ No 25. Wes casa rafarrad to medicel axeminar? Be 26. Placa of Daath (Check only ona) Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpatient Othar: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 10 2 NO 1 Tyes 3 DOA 99.00 28a. Data of Injury (Month, Day Year) 1 27. Menner of Deeth 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: After 1 Natural 5 Panding invastigation 1 Yas 2 No 2 Accidant after death Director: 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Sulcide 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 T Homicida 8 Hospital 24 hours a Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical 29a. Cartifiar (Check only one) To the Within 2 To the 296. Signature and title of certified 29c. License number 29d. Dete signed (Month, Dev. Year) 30. Nema and eddress of person who com ted causa of daath (Itam 23a) (Type, Print) nd Old Court Road 5310 Hunter (9 Lopelly MD 11. Date filad (Month, Day, Year) 32. Registrar's Signeture State

Sparks

DHMH 16 Bay 6/95

Registrar

JAN 2 0 1999



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 19b per F.H G-767 1/20/99 reb Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Max I AM. 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street and number) 4c. County of Deeth MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) XXM 2DF Days Months Hours Yrs. 95 JAN. 6, 1904 212-01-6734 RUSSIA Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 XNo BALTIMORE BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21215 6990 MARSUE DRIVE - APT. 1-D U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) 10 WAREHOUSE MANAGER FOODS 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) LOUIS **MYERS** FREIDA BUCKANTZ 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6990 MARSU DR. #1-D , BALTIMORE, MD 21215 19a. Informant's Neme/Reletionship (Type, Print) FLORENCE MYERS / WIFE 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/14/99 BNAI ISRAEL CEMETERY BALTIMORE, MD 21. Signature of Junerei Service Licens 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 the dise is or compilections that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, leart failure list only one cause on each line. 23a, Part1. Ente Approximate Intervel Between Onset end Death Immediate euse (Final disease or undition resulting in reath) 3 yea Due to (or es a conseque vaporo. Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 100 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Piece of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a, Stete

MD

**Funeral** 

Director

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= 8 permit. Page Department of Important: If any injury or

Pages 1 and 2 should be filed within 72 hours effer on tof Health and Mental Hygiene. Att if Itam 27 is marked other than "natural", or iter

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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Examiner The law requires that the death certificate be ex physician the burial 88 080 for signed by the a should b has e 2 s is certificate ha Physician: this

Division of Vital Records, P.O. Box 68760.

Physician/Medical þ Completed Be 10

27. Menne of Death 1 Natural Certification:

1□ Yes 2□No

2 Accident

3 ☐ Suicide

29a. Certifier

one)

4 Homicide

(Check only

Hospital or Attending To the Hospital o within 24 hours af To the Funeral Di completely filled in

After

Director:

à

State Registrar

edical 29b. Signeture and title of certifie

5 Pending Investigation

6 Could not be determined

28a. Date of Injury (Month, Dey Year)

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at 1 Yes 2 No

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(a) and manner stated.

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how Injury occurred

Randallstown MD

29d. Dete signed (Month, Day, Year) 911/4/4

ed cause of death (Item 23a) (Type, Print) 30. Neme and eddress of person who con

Huter Copeland 5310 Old Court Road 19 W

31. Date filed (Month, Day, Year) JAN 2 0 1999 32. Registrar's Signature

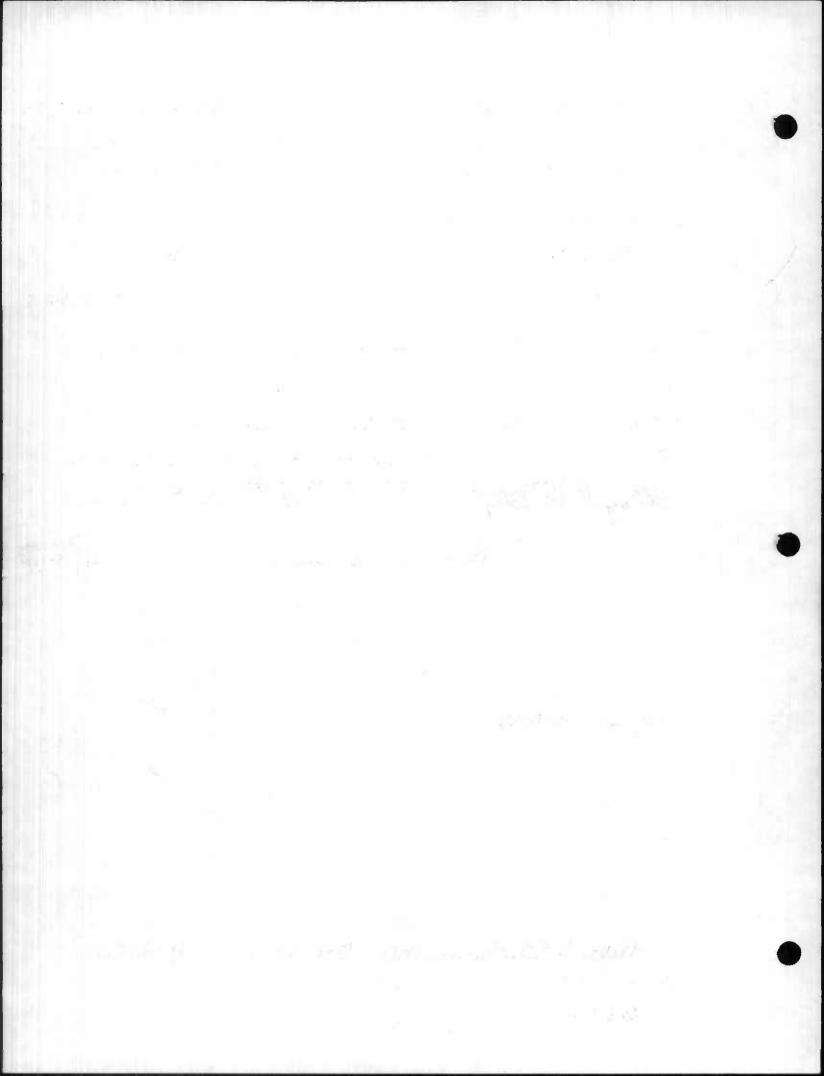
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11, 1999 **Physician** THEODORE R. MOORE SR. JANUARY 6:10 A.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8733 MISSION ROAD. (HOME) **JESSUP** HOWARD, CO. 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth MARCH 2, 1905 Sex 1X□M 2□F 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign **Funeral** Hours 93 213-12-4054 Yrs. HOWARD CO. Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Director 1 X Yes 2 □ No HOWARD MARYLAND **JESSUP** 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 8733 MISSION ROAD USA 20794 by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian, Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
If I flem 27 is marked other than "natural", or iter may or other traumalc event, the Medical Expensival year other traumalc event, the Medical Expensival. Bleck White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: AFRO. AMERICAN 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CEMENT FINISHED MOORE & CO. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) RANDOLPH MOORE **EMMA** MOORE 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) ERNESTINE MOORE 8733 MISSION ROAD, JESSUP, MARYLAND 20794 WIFE 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Depertment of Important: If any injury or once. 4 Donation 5 ☐ Other (Specify) MEADOWRIDGE MEM. PARK 1/15/99 | ELKRIDGE, MARYLAND 22. Name and Address of Facility ESTEP BROTHERS FUNERAL SERVICE, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 23a. Part1. Enter the Hisease, or complications that odused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear, in ture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** 3 months /Medical Immediate Cause (Finat Pancreatic disease or condition resulting in death) 11198-1199 Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ page 2 should be 24b. Were autopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Certification: To 1 Yes 2 No funeral 27. Manner of Death 28a. Date of injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? After 1 Natural 5 Pending investigation s efter death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital of within 24 hours e To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of death (4) Millersul lle MAKY /And 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 10 1999 Registrar

DHMH 16 Rev 6/95

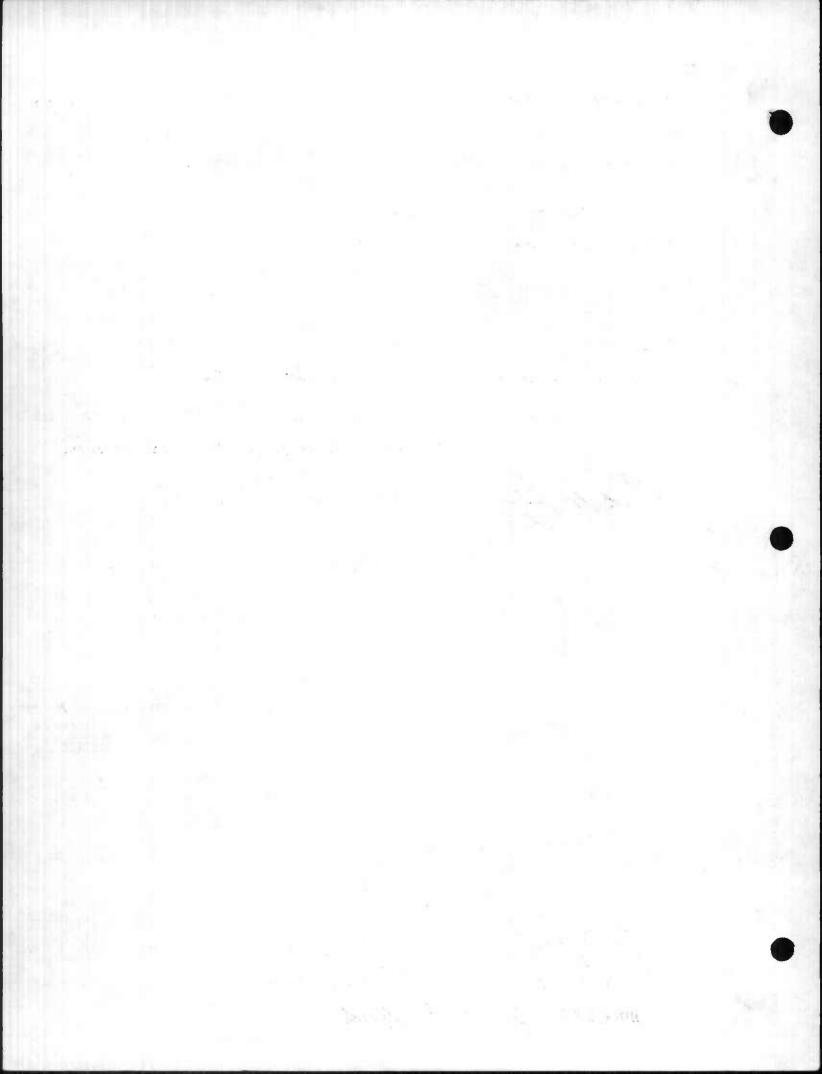


99-0146-005

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sician	Decedent's Name (First, Middle, Last)     Carl Francis Meushaw						f Death		2. Dete of Dea Month JANUARY	Day			
edical miner	4a Facility Neme (If not institution, give street end number)						4b. City, Tov	wn, or Lo	cation of Death	-		0.07 A.H.	
	FRANKLIN SQUARE HOSPITAL						ESS	ESSEX BALTIMORE					
	5. Sociel Security 218-90-		Sex 1XXX 2□F	7. Age (In yrs. 34	last birthday Yrs.	Months Dey		24 Hrs. Min.	8. Date of Birt	12%) 196	4 Gount FLO	ace (State or Foreign try), rida	
dial Examiner must be notified at eted by Funeral Director	10a. State	noce of Decedent  10b. County  10c. City, Town or Location Baltimore  Baltimore									10	od. Inside City Limits	
		10e. Street and Number 3534 Wagontrain Road				10f. Zip Code 2122	O			10g. Citizen of V	Og. Citizen of What Country? U.S.A.		
	11. Maritel Status  12. Wes Decedent Eve Armed Forces?  12. Wes Decedent Eve Armed Forces?  1 Yes 2 No If Yes, Give Yeer or Detes:				ces? 2 X No	I,S. 13	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:					ce - America ck, White, e y: Whit	etc.
Ì	(Sp	15. Decedent's E			16a. Dec	edent's Usual Occ e kind of work do	cupation	of worki	na	16b. Kind of B	usiness/Ind	ustry	
Completed	Elementary/Sec		College (1-	-4or 5+)	Mana Mana	DO NOT use ret	ired)			Liquor	Stor	e	
	17. Father's Nemo	e (First, Middle, Lass B. Meus	shaw Sr	•		311	Jane	r's Neme E M	(First, Middle, Shar	Maiden Suman ff	ne)		
		Neme/Relationship B. Meus			3534		train			imore,	Mary	land 2122	
20a. Method of Disposition  1 Burial 2 Cremation 3 Removel from Stete  4 Donetion 5 Other (Specify)  20b. Place of Disposition (Name of Semetery, crematory, or other place)  Washington Crem.  Date  1/16/99  Laurel, Mar													
		the disease, or consent teilure. List only	plant ons that ca	used the deat ech line.							aryla	nd 21206 Approximate Intervel Between Onset end Deeth	
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DHMH 16 Rav 6/95



Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔍 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January **Physician** Mary Majerowicz 1999 00:52 AM 17, /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 3/29 Pg 1931) 9. Birthplace (State or Foreign Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 1□ M 28 F Yrs. 212-14-1776 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28s-f show r than "natural", or learns 23a or 28s-f shor the Medical Examiner must be notified at Perry Hall Baltimore MD 1 Yes 2 No Director 10e. Street and Number 9339 Hines 10f. Zip Code 10g. Citizen of What Country? Estate Drive 21234 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore. Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: if fleen 27 is marrised oth any Injury or other traumatic even obcs. Be Florence Amoroso Michael Minossi 19a. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, 9339 Hines Estate Drive Baltimore, Walker Mary F. 20b. Place of Disposition (Name of 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removel from Stete 1/20/99 Baltimore, Maryland Faith Cemet. Gardens of 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility John C. Miller Inc. Maryland 21206 6415 Belair Road Baltimore, that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, cardia on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examine Examiner NOT KNOWS physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 edical Due to (or as a consequence of): Physiclan/M 987 P.O. Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records. by been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1 Yes 2 No 1 Yes 200 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) To. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Netural Division or Attending 5 Pending investigation 4 hours after death. Funeral Director: After lely filled in by the fun 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hour.
The Funeral Direction by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) within 2. Σ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 7 30661 Revain 30. Name and address of person who completed cause of death (from 23a) (Type, Print) 51 REESH K: 560 XOCU KAVLU BOOK / Prolite work of the TRIPURANCENT

Registrar

State

**DHMH 16 Rev 6/95** 

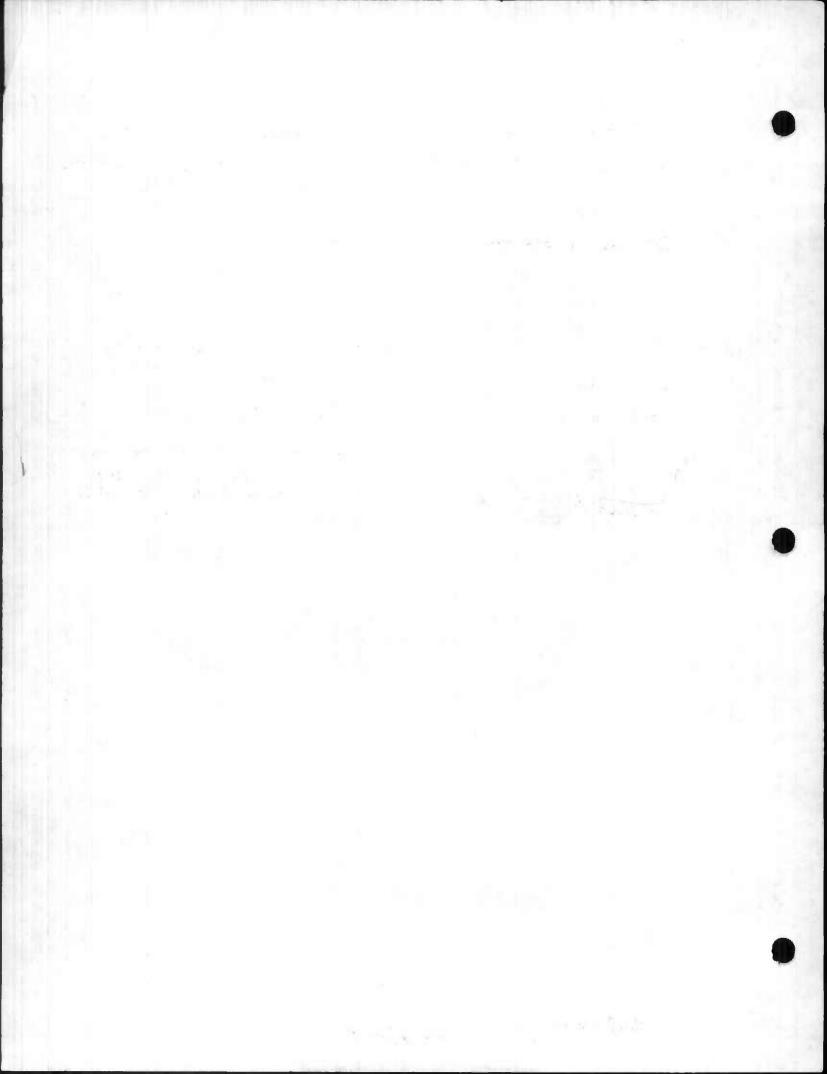
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31. Date tiled (Month, Day, Year)

32. Registrar's Signature

J. Aparks

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Pleas: Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Deta of Death 3. Time of Death Year Neubert 6:15Am 20,1999 January 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, give street and number) 4c. County of Death If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) (Month, Dey, Year) rowson Health Services 1 timore Manorcare Birthpleca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Months 1□ M 2⊠ F 215-07-514 Usual Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Baltimore Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21234 Road 8301 Edgedale 12. Wes Decedent Evar in U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indien, Black, Whita, etc. 11. Maritel Status 1 Nevar Married 2 Married ☐ Yas 2 No Yes, Giva 1 Yas 2000 White 35 Widowed 4 □ Divorced Yaar or Datas: 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Horrie Homemaker 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Meidan Sumama) Elizabeth Sweeney Fitch Joseph 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Straet end Number or Rurel Routa Number, City or Town, Steta, Zip Code) 8301 Edgedale Rd. Baltimore, MD 21234 Stinchcomb Dorothy 20b. Piace of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition Data 20c. Location - City or Town, Stata San. 22, 1 Burial 2 □ Cramation 3 □ Ramoval from State Oaklawn altraverent 4 Donation 5 Other (Specify) 1999 21. Signature of Funeral Sarvice Licensae 22. Name and Addrass of Facility 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not entar the mode of dying, such as cardiec or raspiretory errest, shock, or haert feilure. List only one cause on aech line. mo 21234 Approximata Intarval Between Onsat and Death Immediata Causa (Final diseesa or condition rasulting in daath) Sequantially list conditions, if eny, leading to immediata causa. Entar Underlying Causa (Diseasa or injury that initiated avants rasulting in daath) Lesf Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings eveilabla prior to complation of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was casa raferred to medical axaminar? 26. Placa of Daath (Check only ona) Othar: 4 Nursing Home 5 ☐ Residanca 6 ☐ Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Data of injury (Month, Day Year) 28c. injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 1 Naturai 2 Accidant 5 ☐ Panding 1 TYas 2 No Invastigation 3 Suicida

attending physician and for use as the buriel-transit requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, USB as t signed by the a page 2 s certificate or Attending Physician: funeral director. this After 24 hours efter death.

Funeral Director: Al

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r than "naturel", or flems 23a or 28a-f show the Medical Examiner must be notified at

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any Injury or other treumatic event, page.

**Physician** 

/Medical Examiner

altimore, Maryland 21215-0020

Physician/Medical Completed by Be Certification: To

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27. Mannar of Deeth

29a. Certifier (Check only one) 29b. Signature end fitla of certifian

4 Homicida

6 ☐ Could not be determined

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify)

28f. Location (Street and Number or Rural Route Number, City or Town, Steta)

TX Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and mennar as stated.

Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and mannar stated. 29c. Licansa number 29d. Data signad (Month, Day, Year)

30. Neme end address of person who completed cause of daeth (Item 23e) (Type, Print)

9512 HARFORD RD, BALTIMORE 21234

31. Data filed (Month, Day, Year) JAN 2 0 1999

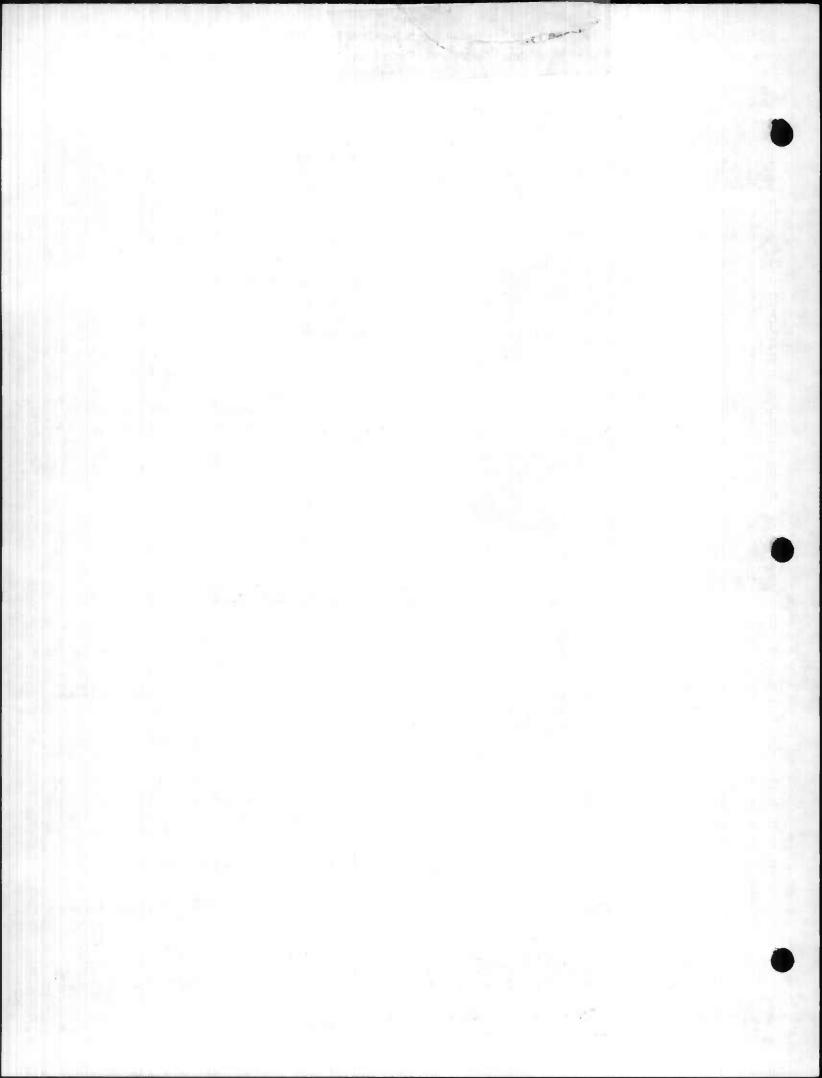
32. Ragistalr's Signatura

State Registrar

Hospital

To the Hosp within 24 ho To the Fune completely f

**DHMH 16 Rev 6/95** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Date of Death 3. Time of Death OLSZEWSKI 12:07 FRANK JANUARY 1999 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GOOD SAMARITAN HUSPITAL If Under 24 Hrs. 8. Date of Birth Hours Min. 7/25/1919eer) 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign Months Days Mary Tand 213-18-7066 79 Yrs. Usuel Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Baltimore Baltimore 1 Yes 2 No 10a Street and Number of Avenue 10g. Citizen of What Country? 105 Zip Code Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator Steel Company 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Joseph Olszewski Mary UNK. 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearl E. 708 Elmwood Avenue Baltimore, Maryland 21206 Olszewski 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burlet 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Memorial Gard. 1/20/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility John C. miller m of Funeral Service Licensee 6415 Belair Road Baltimore, Maryland 21206 Fant. Enter the distance, or complications that based the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart carure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediete Ceuse (Finel disease or condition resulting in death) a acute Myocardial Infarction 7 days Due to (or es a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Due to (or es e consequenca of): Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Localion (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as stated. (Check only one) 2 Medicat Exeminer: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date and plece, end due to the cause(s) end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) brew mo

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State

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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**Physician** 

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Examiner

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Division of Vital Records, P.O. Box 68760

Examiner

Physician/Medical

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31. Date filed (Month, Day, Year) Registrar

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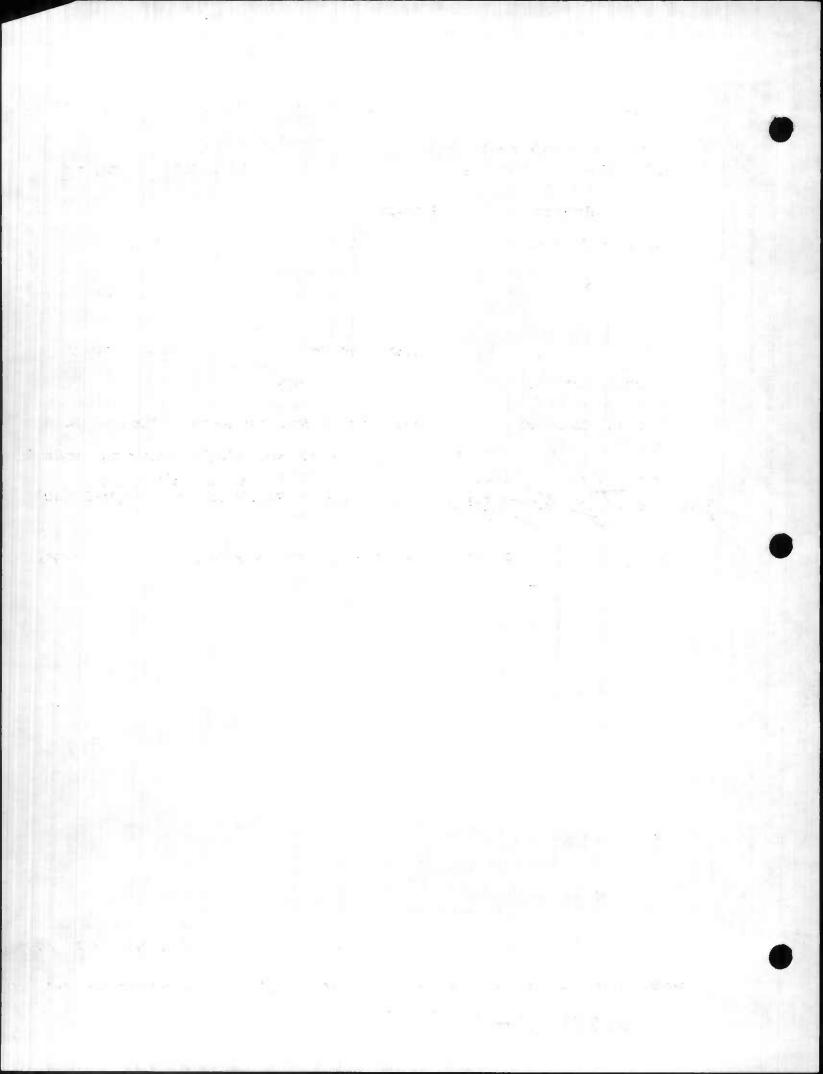


30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

NANAKU KUROPAMD GOOD SAMARITAN MOSPITAL SEOI LOCH RAVEN BLUD BALTI MERE MPZIZZZ

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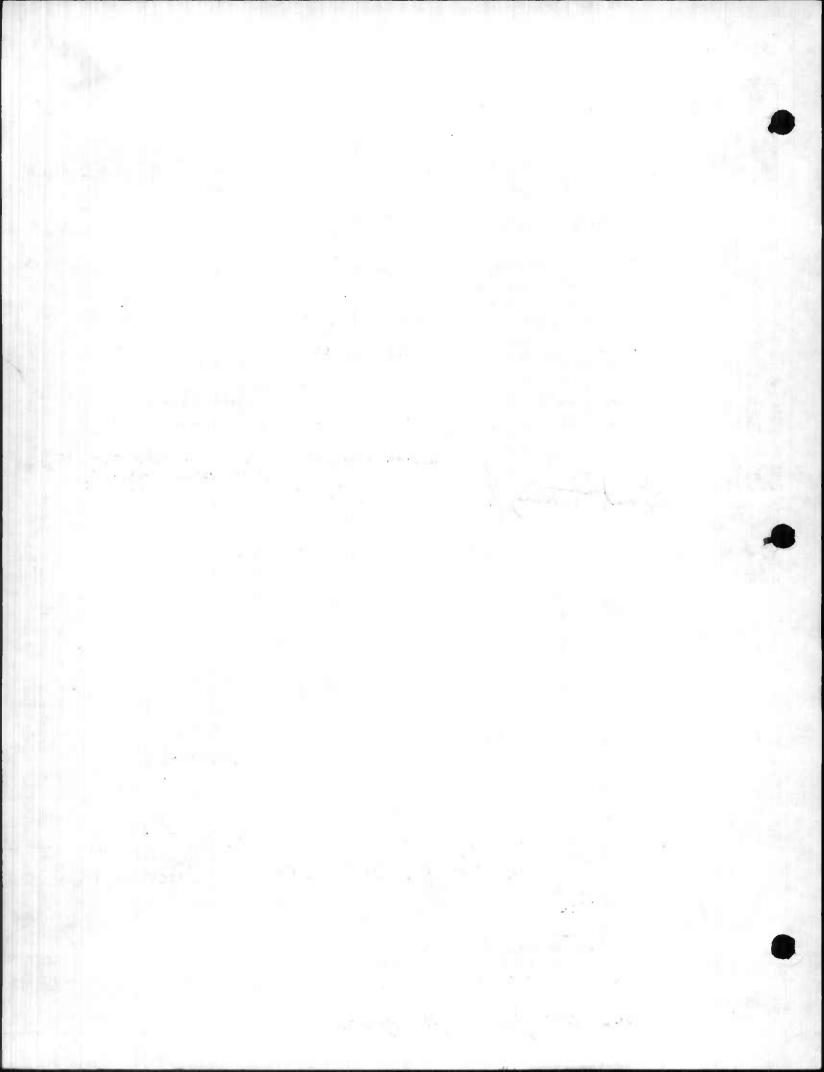


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	Certificate of Death  1. Decedent's Name (First, Middle, Last)  2. Date of Death  3								3. Time of Death		
n al	Thomas Edward Parks						Januar	y 09, 1	999	2:50 P.M.	
	Facility Name (If not institution, g					4b. City, Town,	or Location of Deal	th 4c. Coun	ity of Death		
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5		Sex 7.		Lot Data Joseph	If Under 1 Year Months Days		in. (Month, D.	rth ay, Year)	9. Birthp	place (State or Foreign	
U	242-68-8725 58 TS						pune 1	4, 1940	North	Carolina	
	Da. State 10b. County		10c. Cit	ty, Town or Loca	ition				1	0d. Inside City Limits	
Director	NC Wayne		G	oldsboro	)					1)X Yes 2 □ No	
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na ka	t. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	Armed Force	s? XNo	If Y	Yes, specify Cub	an, Mexican, Pu	(Specify Yes or Netro Rican, etc.)		lack, Whita,	etc.	
Completed	15. Decedent's			16a. Deceder	nt's Usual Occup	pation	undina	16b. Kind of			
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	11th Grade	-41		Self	Employ				k Driv		
5	7. Father's Name (First, Middle, La.	SI()					leme (First, Middle	, Maiden Sumi	ame) (m	Known	
-	Elijah Parks 9a. Informant's Name/Relationship	(Type Print) 1/11	fe	19h Mailing	Address /Street	Eliza	beth  Rural Route Numb	ner City or Tow	m State 7in	(Code)	
15	Linda Lee Parks				ines Dri		oldsboro		7534	- 5500)	
2	Da. Method of Disposition			Place of Disposit cemetery, creme	tion (Name of		Date	20c. Location		own, State	
200	14 Burial 2 Cremetion 3 4 Donation 5 Other (Speed		10	oadhurst			Jan 14	Seven	Spring	os. NC	
2	t. Signature of Funeral Service Lio	1 / 1	DI	22.1	Name and Addre		utter Fu		lomes,	Inc.	
	mmediate Cause (Final isease or condition assulting in death)	. Multip	Due to (d	juries or as a conseque or es a conseque	ence of):	omplicat	cions				
Cai	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury nat initiated events asulting in death) Last			1							
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Complete								10	Yes 2 No	1[	Yes 2□ No
L	5. Was case referred to medicat examiner?	Hospital: 150			_ Ot	hor	Death (Check only				
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L	1 X Yes 2 No 7. Manner of Death		Day Year)	Injury 8 • 37 P		hiury at Work?  1 River of truck			Harr ushick		
L	7. Manner of Death 1 Natural 5 Pending		28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)  30  28f. Location (Street and Number or Rural Roc City or Town, State)							al Route Number,	
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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 9 9 9 8

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2 sho and is summer	19e. Intorment's Neme/Reletionship (7	ype, Print)	19b. A	Aeiling Addres	s (Street	end Number o	r Rural Route Numb	per, City or Town,	State, Zip C	Code)	
	Kathryn Q. Cooper/	sister	390	4 Wispe	ering	0aks	Place Vir	ginia Be	ach,	Va. 23	3445
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90119	Adam)	19/2	)								
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Physician	shock, or heart teilure. List only o	ne cause on each line.							: 1	Interval Between Onset and De	/een
/Medical	tmmediate Cause (Fine) ACUTE RESPIRATORY FAILURE									1-3 D	AYS
Examiner	disease or condition resulting in death)	8.									
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that the death ce ed by the attendi detached for us		sulting in t						Id tobacco use contribute to the cause of death  Yes 2 No 3 Probably 4 Unknow			
The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit Completed by Physician/Medical Examir				24a. Was an autopsy performed?						24b. Were autopsy tindings available prior to completion of cause of death?	
he lav e has age 2							100	Yes 2□No	120	Yes 2□N	No
certificate rector, pag	25. Wes case referred to medical					26 Place of	Deeth (Check only			(103 ED)	-
sician: certificator lirector	axaminer?	Hospitel: 1 Inpatient 2	1 EDIO	atient 3 C	OA Oth	or:	ng Home 5 ☐ Res		as (Canalla)		
Physic or this or and direction 7: To	27. Menner of Death	28a. Date of Injury	28b. Tin		28c. tnjur Wor	4 140128		how injury occur			
ding h. Afte fund fund	1 Neturel 5 Pending 2 Accident investigation	(Month, Day Year)	Inju	iry M		k? Yes 2 □ No					
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	3 Suicide 6 Could not be 4 Homicide determined	28a. Plece of tnjury - At h building, etc. (Speci	nome, fam ify)					(Street and Numb wn, State)	per or Rurel	Route Numb	er,
n 24 hours n 24 hours he Funeral pletely filled	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	reician: To the best of my kno iner: On the basis of examina and manner steled.	owledge, o ation and/o	leath occurred or investigation	at the tir n, in my o	ne, date end p pinion, death o	lece, end due to the occurred at the time	cause(s) and ma date end place,	anner as sta and dua to l	ited. the cause(s)	
Me Me	29b. Signature and title of certifier	The state of the s		25	c. Licens	e number		29d. Date signe	d (Month. D	Pay, Year)	
	/ lalen				440			1/15/9			
N. X.	Milled				1.14	r seef Ned		111/9	7		
10	30. Name and address of person who o				AD ~	(D) (C) (C) (C)	MANDALL	WID G40	101/		
				KK KU	HD [	UMPUN	, MARYLA	AND EIE	, KIM		
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	eture	1	,						

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 18,1999 10:05AN Mary Roberson 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street end number) Ge (In yrs. last birthday) If Under 1 Year Months Deys Hours Min. Month, Days Min. GENESIS Eldercare 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months 1□м 2√2 F Deys 212-30-3219 90 VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e Stete 10h County 1 Yes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4317 Marble Hall Road Apt. #161 21218 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 TNo If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Hot Shop Cafe Foods Unknown NA 18 Mother's Name (First Middle Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Yancy Nannie Price Issac 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Pnnt) 4317 Marble Hall Road Baltimore, Maryland William Roberson 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete MD 20e. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removel from State Cedar Hill Cemetery 01-22-99 Anne Arundel Co, 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, only one cause on each inc. Approximete Interval Between Onset end Deeth Asperation Mar Immediete Ceuse (Finel diseese or condition resulting in death) Due to (er es e consequence of): Ovelvo Varcular Academ 1400 Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of): Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 1 No 3 Probably 4 Unknown Haematoma 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Plece of Deeth (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

p

MD

**Funeral** 

Director

the

ODErSON, Mary

7 is marked other than "naturel", or items 23s or 28s-f shor traumstic event, the Medical Examinar must be ricitlied at

1 and 2 should be filed within Health and Mentel Hygiene. Im 27 is marked other than

Health item 27 i

injury or

Pages 1 nent of P

Physician/Medical

Completed

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edical

Division of Vital Records. P.O. Box 68760. paga 2 Hospital or Attending Physician: uneral director, after death.

Subdura

	examiner?	2K No	
0.7	Manager		

5 Pending investigation

6 Could not be determined

28e. Dete of Injury (Month, Dev Year)

8109

28b. Time of

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Plece of tnjury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier

1 23 Maturel

2 Accident

4 Homicide

3 🗀 Suicide

1. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

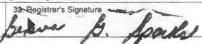
30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

Attending Doctor

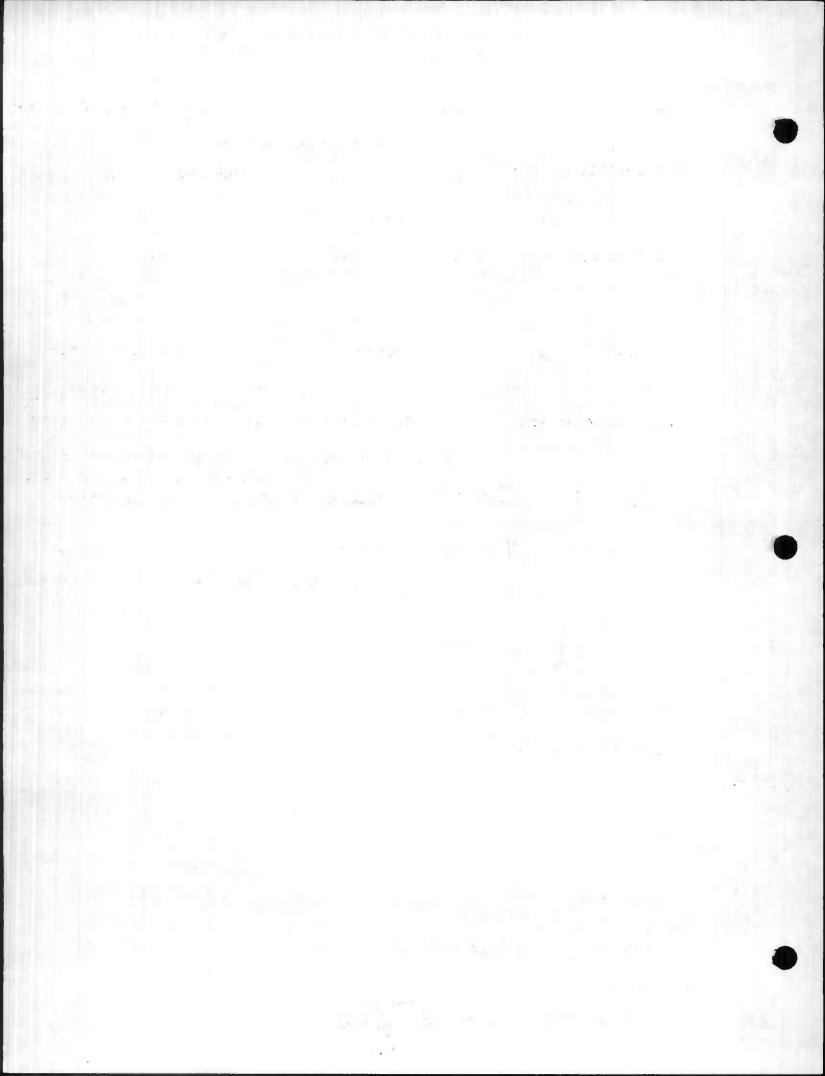
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RITCHE WAY, PASADENT, MO 21122

State Registrar C-V-CYRIAC. M.D 31. Dete filed (Month, Day, Year)



To the Hospital of within 24 hours at To the Funeral D completaly filled



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Year 10:07AM 1999 JANHARY DECCIE 14 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maris Ja + 1 m Stella AT era MORE If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1 M 2 F 212-40-6405 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10a Stete 10b. County 10d. Inside City Limits NDYes 2 No Director Ma 28a-f ltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or flams 23s or 2909 Funeral Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11 Meritel Status Bleck, White, etc. 1 Yes 2 No 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. Specify: þ 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Sect Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) GRACIE College (1-4or 5+) Homemster 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 88 Pages 1 and 2 should be nent of Health and Mental History 0 STECKE (200de REAVIS, 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Ilem 27 is any injury or other tree homes E. tecera hughter 21213 TOXSCOR 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete N☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Memorial 4 ☐ Donetion 5 ☐ Other (Specify) l'endelltour, Md 21. Signature of Funerel Service Licensee 22. Name and Address at Facility
Jeff Miller P.C. Funeral Home & 1639 N. Broadway

1639 N. Broadway

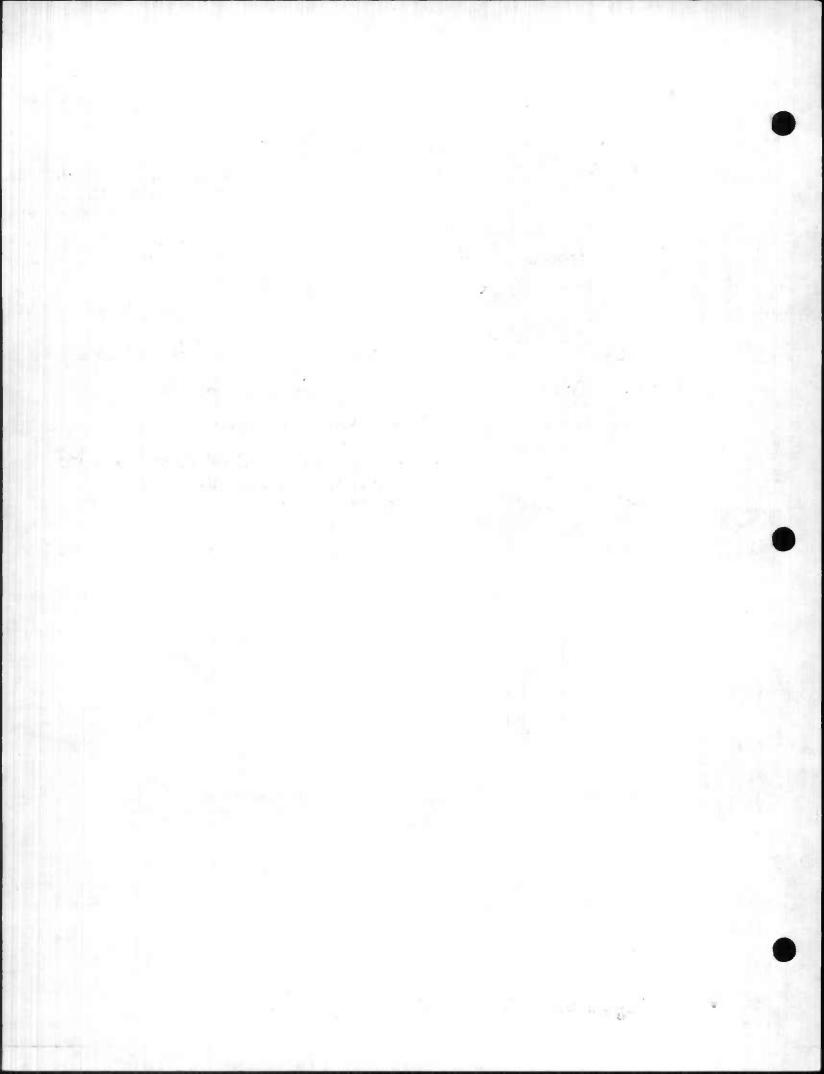
marke of dying, such es cardiac or respiretory arrest, lles 23a. Part 1. Enley the disease, or complications that caused the deeth. Do not enter the mode of dying, such shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical of Unknown Promon Adenousmens Examiner Due to (or as a consequence ot) Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence ot): P.O. Box 68760. Physician/Medical the the Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t, 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yss 2 No 3 Probably ate has been signed page 2 should be de Records, Be Completed by 24b. Wera autopsy findings evailable prior to 24a. Wes en autopsy performed? completion of cause of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: director, 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) STELLA MARIS AT MERCY Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOV PLY 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury et Work? After 5 Pending investigation 1 Naturel s after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 3 4 Homicide filled in within 24 hours a To the Funeral D completely filled Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29e. Certifier (Check only one) \$ 29b. Signetare end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 0 040854 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bulture Part Pl 21207 St MD Resober 31. Date filed (Month, Dey, Year) JAN 2 0 1999

**DHMH 16 Rsv 6/95** 

State Registrar

Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1999 **Physician** MATU: PAULINE RICHARDSON Jan 15 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner FOWARD OWARD JENERAL OUNTY If Under 24 Hrs. 8. Date of Birth (Month, Day, 09-28 5. Social Security Number 6. Sex 7. Age (In yrs. last birth day) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Deys Hours Min 242.51.4966 Usual Residence of Decedent Yrs. **Director** with the Marylend 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show 7 is marked other than "naturel", or itema 23a or 28a-f show treumstic event, me Medical Examinat must be notified at 1 Yes 2 No BALTIMORE MO NIA Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? STREET WASHINGTON 201 21231 USA permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or flama 23a any injury or other treumatic event, the Medical Experience pages. N. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Meritel Status Black, White, etc. 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: BLACK Specify: ρ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA ARE KEEPING EALTH GRADE TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SARAH WILLIAMS MIDDLETON ANDREW 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WAY, Eucon ( ELOISE MITCHEI WHITWORTH TY MO JAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State BAUD. 1-19-99 4 ☐ Donation 5 ☐ Other (Specify) EMBIERY VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Survivo Licensee 23a. Part 1. Enter the discussion or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart initian. Let only one cause on each line. 21229 BALTO. MD. Approximate Interval Between Onset and Deeth **Physician** Acute My ocourd, Al Ischein Immediate Cause (Final disease or condition resulting in death) /Medical hours Examiner Due to (or as a consequence of) Examiner Atherosclevotic Cardiovascular Disease eours attending physician and for use es the buriel-transit certificate be executed Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): requires that the deeth 23b. Did tobacco usa contribute to the causa of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. the 1 Yes 2 No 3 Probably 4 Minknown 6 ئە hy pertension Division of Vital Records. þ 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed peen The law 2 eged certificate has 1 ☐ Yes 2 ☑ No 1 Yes 2 D N To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 TER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier edical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) com/6, 199 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4565 Hemlock Cone Way Ellicott City Mb PATRYCE A. TOTE MY

DHMH 16 Rev 6/95

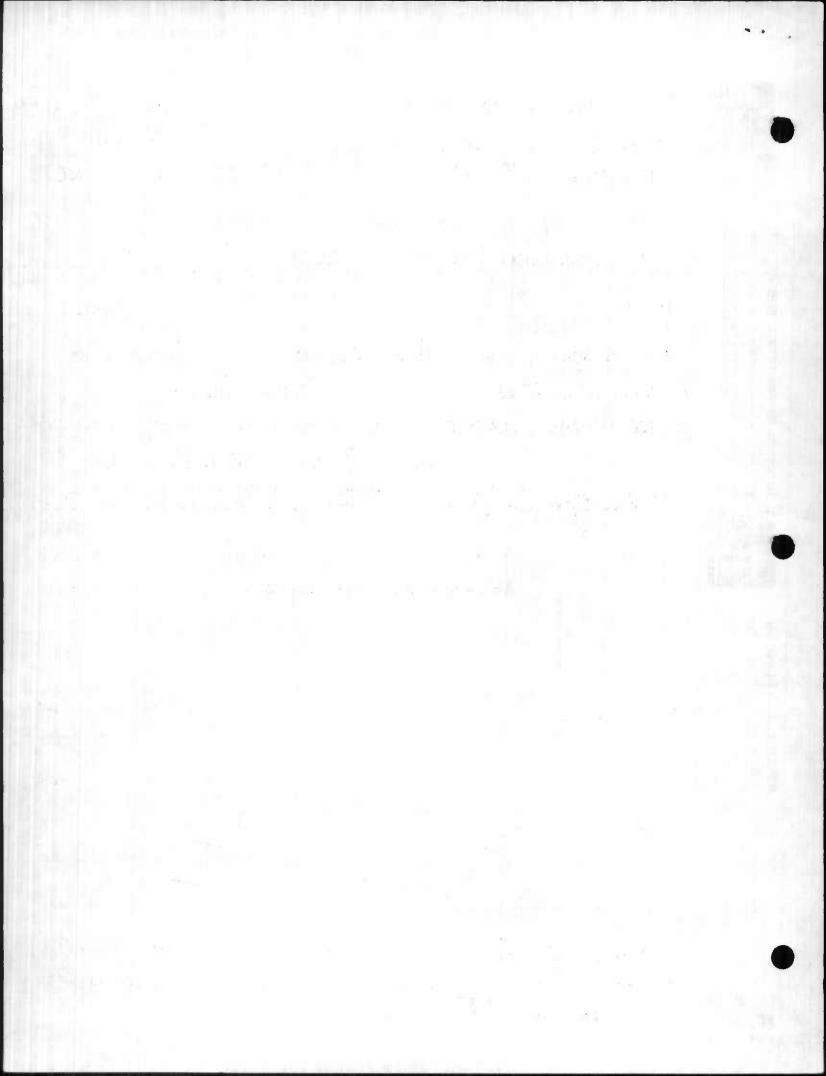
State

Registrar

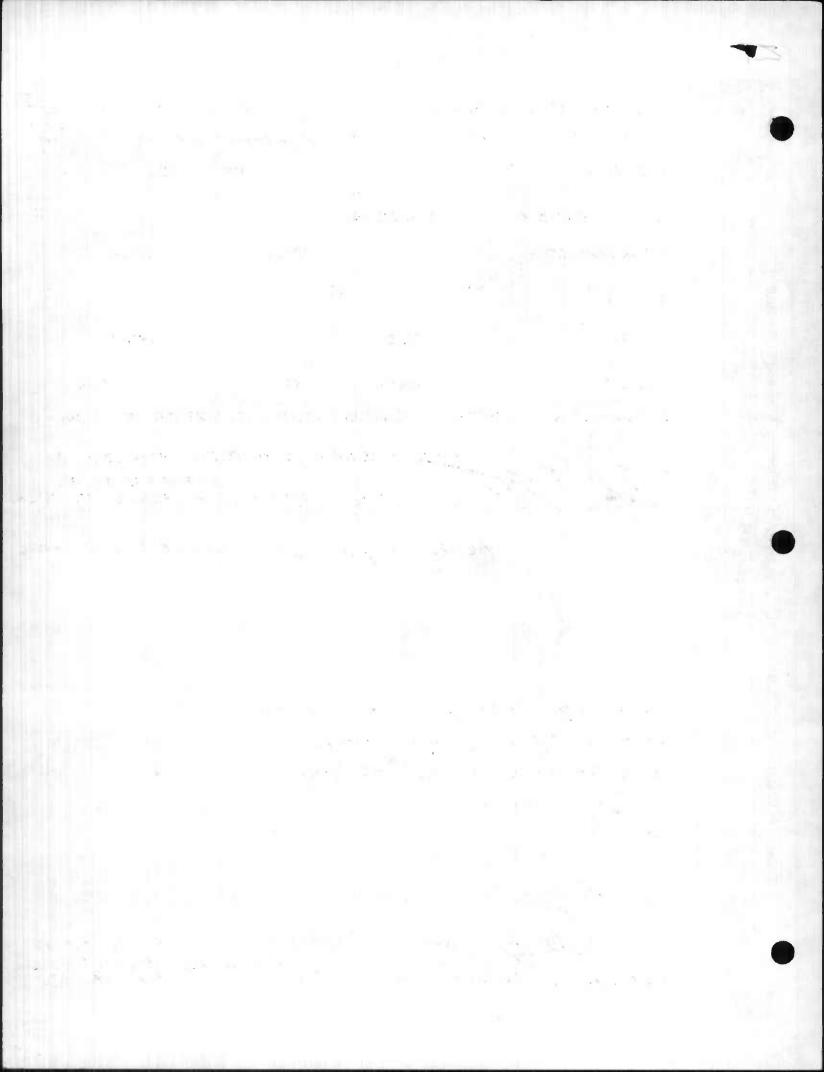
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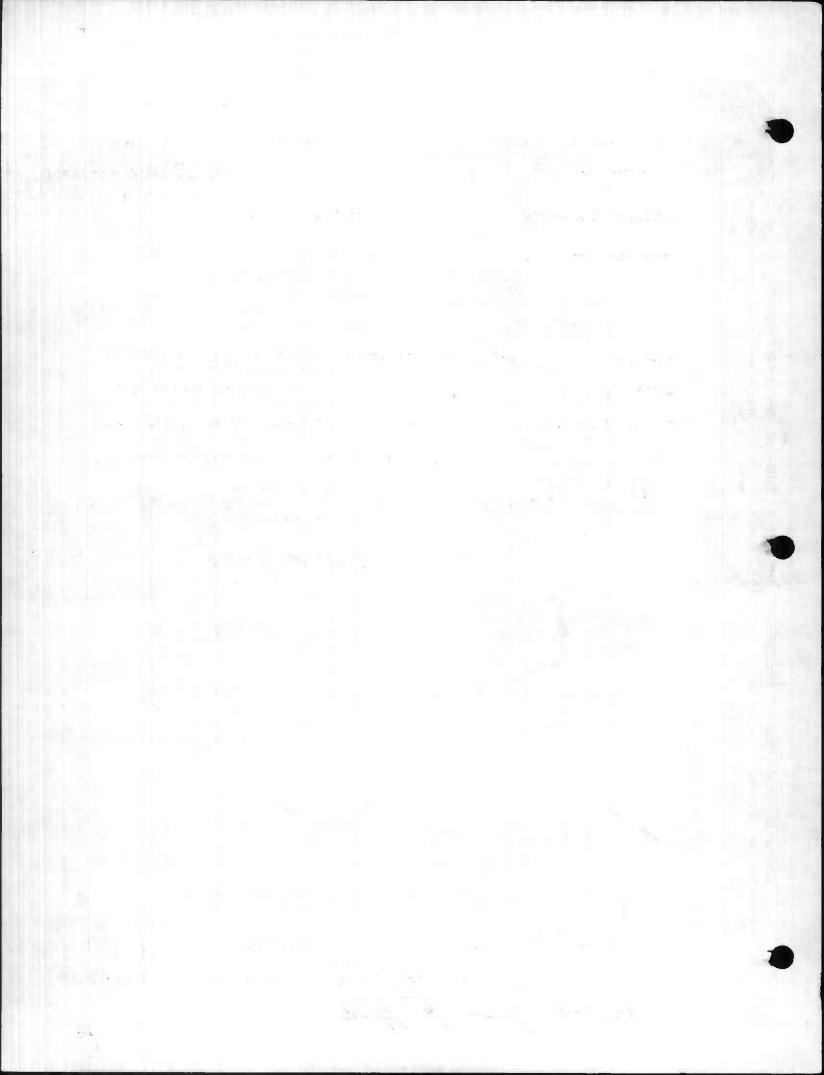
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death 25 Month Yaai **Physician** KESKICK BE7 JANUARY /Medical Dru 4c. County of Death 4a Facility Name (If not Institution, give street and number, 4b. City, Town, or Location of Death Examiner HOSPITAL NONTHWEST CENTER BALTIMONE RHOUDALIS TOWN If Under 24 Hrs. 8. Date of Birth Houra Min. (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Days 10 M 2 F Months 054-10-4842 81 3, NY Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Insida City Limits r than "natural", or Name 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 X No Director MD BALTIMORE REISTERSTOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours efter deeth with 322 ACADEMY AVENUE 21136 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, etc. 12. Was Decedent Evar in U,S. Armed Forces? 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give XX 1 Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: þ 3 Widowed 4 □ Divorced WHITE Year or Dates: 16a. Decadent's Usual Occupation (Give kind of work done during most of working SALES (SALES) Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) RETAIL marked other 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Peges 1 and 2 should be Department of Health and Mental Important: If item 27 is marked or PHILLIP **BRODSKY** IDA GILDE 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS D'AMBROSIA / DAUGHTER 322 ACADEMY AVENUE - REISTERSTOWN, MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 LIBERTY PARK SHAAREI ZION 1/17/99 RANDALLSTOWN, MD 21. Signature Funeral Service Libenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onsat and Death and 1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** pupo cardine /Medical Immediate Cause (Final INTARCTION disease or condition resulting in death) **Examiner** Due to (or as e consequenca of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in deeth) Lest Due to (or as a consequence of) Box 68760 The law requires that the death certificate be Physician/Medicai Due to (or as a consaquence of): signed by the aid be deteched for Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobecco use contribute to the cause of death? P.O. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Antones WITH Records, þ VENTR'Cular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy peen hes e 2 CONEBRO VASCO Old 2 19 No 1 Yes 2 No 1 Yes certificete Division of Vital 25. Was case referred to medical axaminar? or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Impatient 2 ER/Outpatient 3 DOA this After this funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Watural 5 Pending investigation death. 1 ☐ Yas 2 ☐ No 2 Accident 24 hours efter deatl Funeral Director: 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Hospital edicai 29a. Certifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. pletely (Check only one) 2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Within 2 29d. Date signed (Month, Day, Year) 29c. Licensa number 29b. Signature and title of JANUARY 14,1899 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) KORTHWEST HOSPITAL CENTER CONANTA NI PHNDALLS TOWN 21133 OLCANDO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Seneva JAN 2 0 1999 Registrar



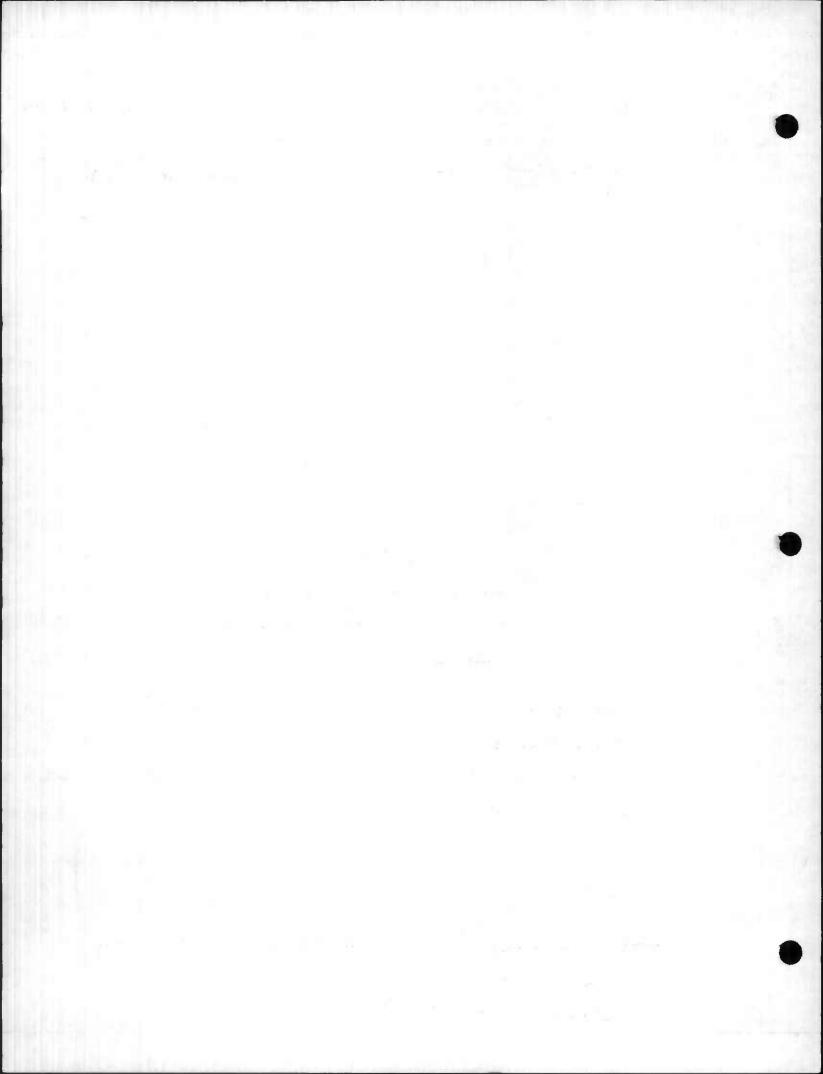
State of Maryland / Department of Health and Mental Hygiene O

Certificate of Death Item: 4b per M.D G-767 1/20/99 reb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 5, 1999 Conrad 12:45 a.m. /Medical 4b. City, Town, or Location of Death ROSSVILLE 4e Fecliity Name (If not institution, give street and number) 4c. County of Death Examiner Genesis Eldercare Franklin Woods Baltimore County Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 180M 2□ F Months 219-18-9395 Yrs. 76 1922 Maryland Director Nov. Usual Residence of Decedent with the Meryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Maryland Baltimore Baltimore County 1 ☐ Yas 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7809 Blue Grass Rd. 21237 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Heelth end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23, any injury or other traumatic event, the Mental Escritor main Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Bleck, White, etc. N Yes 2 No If Yes, Give Year or Dates: WW 11 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 OXNo Specify: Specify: by 3 ☐ Widowed 4 🖾 Bivorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Western Electric N/A Machinist 12th grade 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Wilhelminia Remensnyder Conrad Ross 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Mr. Lawrence D. Ross 7809 Blue Grass Rd. Baltimore, Md. 21237 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition X Burial 2 Cremation 3 Removel from Stete Zion Church Cemetery 1+8-1999 Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signeture of Funeral Service Licansee any le Lassahn Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 7401 Belair Road Baltimore, Maryland 21236-4625 Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting In death) /Medical Prostate Cancer Metastatic 12 mo. Examiner Due to (or as a consequence of) Examiner and I-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieled events resulting in death) Last Due to (or as a consequenca of) physician ar Box 68760, Physician/Medicai Due to (or as a consequence of): 88 attending ed by the a 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ should 24a. Wes an autopsy performed? 24b. Were autopsy findings aveilable prior to Completed completion of cause of deeth? 785 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 27. Manner of Deeth 28c. injury at Work? 28d. Describe how injury occurred 28e. Date of injury (Month, Day Year) 28b. Time of Certification: After 5 Pending investigation 1 Netural hin 24 hours after death.

The Funeral Director: After a pletaly filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certitier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, end due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year) 2 049390 m. D 30. Name end address of person who completed cause of death (item 23a) (Type, Print) MYO MIN (M.D.) G830 HOSPITAL DR. # 206, BALTIMORE MD 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 0 1999 Registra



			State of Maryla		icate of			Reg. No.	U	0374	
Physic /Medi		1. Decedent's Name (First, Middle, Las HAZEL G	2. Dete of De Month	Deeth 1 Year 1999 01:21							
Exami		4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Dea  GOOD SAMARITAN HOSPITAL  BAUTIMORE									
Funeral Director		5. Social Security Number 220 - 03 - 4387 1	ex 7. Age (In y		Under 1 Year onths Deys	If Under 24 Hrs Hours Min.	(Month, Da	th y, Year) 11924	9. Birthp Coun	lece (Stete or Foreign	
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21215-0020  d within 72 hours after death with the Maryland glene. In then "natural", or fleme 23s or 28s-f show in the Medical Examiner, must be notified as	by Funeral Director	11. Maritel Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forcas? 1 ☐ Yes 25 No tf Yes, Give Yeer or Detes:	If Yes	Decedent of F s, specify Cub Yes 2 No	lispanic Origin? (S en, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Specify	e - Americ ck, White, v: B		
72 hours	Completed	15. Decedent's Ed (Specify only highest gre	ucation de com <i>pleted)</i>	16e. Decedent'	of work done	during most of wo	rking	16b. Kind of B	usiness/Inc	dustry	
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Division of To the Hospital or Attending Phenith 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be datermined		28f. Location (S City or Tox	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)						
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Schlen 1999 George 15:20 PM JANUARY 15 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS HOSPITAL BACTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 9 Months -32-962 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Cumberland 1-11 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. Wher than "naturel", or items 23a or and, the Medical Examiner must be 100 Street ourtland Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, atc.) 14 Bace - American Indian 11, Marital Status Black, Whita, etc. 1 ☐ Naver Marriad 2 ☒ Marriad 1 Yes 2 No If Yas, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) College (1-4or 5+) Elementary/Secondary (0-12) rucking Dispatcher 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middle, Last) Sch Calver beorge JOYCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) vonne M. Schleu 4709 Courtland CampHill, PA 1701 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jan. 19 1 DBurial 2 Cremation 3 Ramoval from State Gate of Heaven Cem 4 Donation 5 Other (Specify) Mechanicsburg 1999 21. Signature of Funeral Service Licansee 22. Nama and Address of Facility cina pel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Asperzillus week Due to (or as a consequence of): Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medicai Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient To 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 12 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

**Funeral** 

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Peges 1 and 2 should be filed within 72 hours efter deeth with 1 aneat of Health and Meriel Hygiene.
Ant: If item 27 is marked other than "natural; or items 23a or italy or other traumation.

In yor other traumatic avant, its Medical Estamine markets.

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**Physician** 

/Medical

Examiner

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After

efter deeth Director:

24 hours

To the Hosp within 24 hor To the Fune completely fi

or Attending Physician:

that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

MD JAN 2 32. Registra/s Signature 0 1999

MD

30. Name and address of purson who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifler

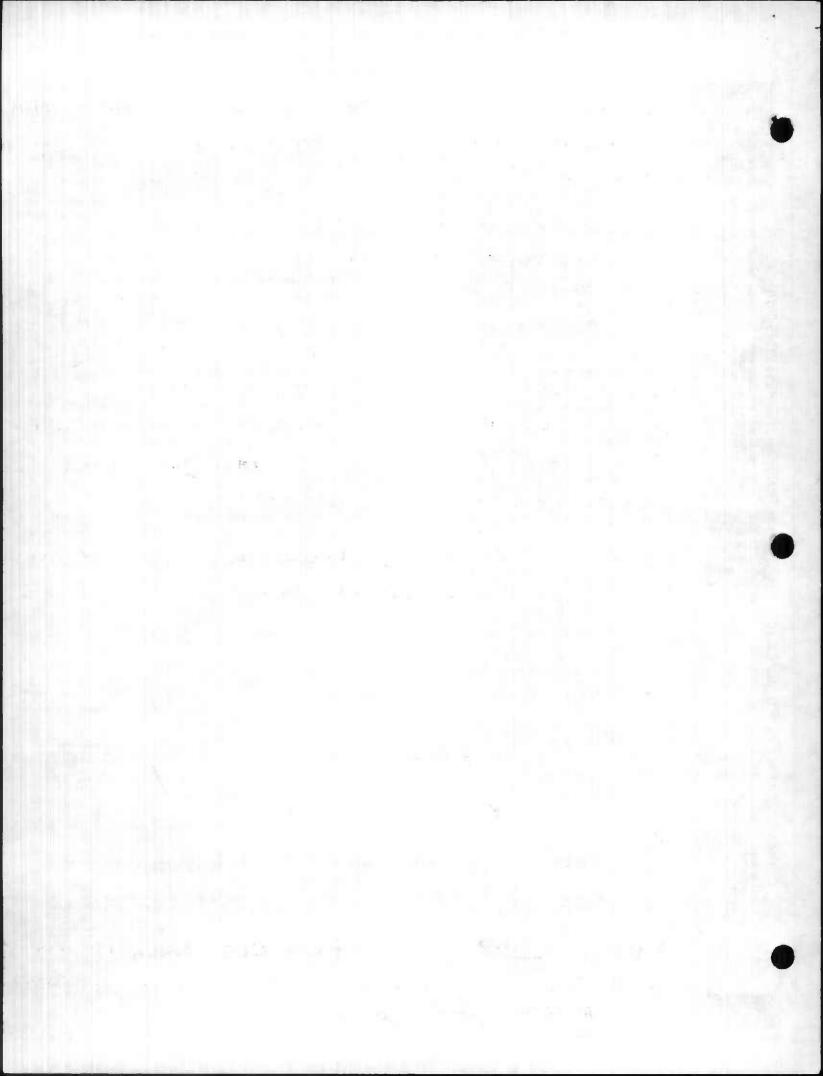
Ceroline

29c. License number

29d. Date signed (Month, Day, Year)

January

, Baltinore



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month KENZIE BARNES SMITH 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or, Loc ation of Death Baltimore Willnder 24 Hrs If Under Months 5. Sociel Security Number 9 Birtholece (Stete or Foreign Age (In yrs. last birthday) Days DOM 20 F Hours MARYLAND 215-40-8828 55 Usual Residence of Decedent 10e Stale 10b. Counts 10c City Town or Location 10d. Inside City Limits 1 Yes \$ No MARYT AND Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 103 ASPRINWOOD WAY APT C 21.237 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XIXes 2 No If Yes, Give Year or Dales: 61/65 1 Never Merried 2X Merried 1 Yes 2 Não Specify Specify: FLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th grade UNEMPLOYED: NONE 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) BERNAFD SMITH CLEMENZA G. SMITH 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Aspring od Way Apt. C., Baltimore, Maryland Brenda L. Smith/Wife: 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Buriel 2 Cremetion 3 Removal from Stete 1-25-99 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST OWINGS MILLS, MARYLAND 21, Signature of Funeral/Service License 22. Name and Address of Facility WII LIAM C BROWN COMMUNITY FUNEFAL HOME PA 1206 W. NORTH AVENUE 23e. Pert1. Enter the disease, or complications thei caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Ceuse (Final disease or condition resulting In death) Due to (or as a consequence of) Arteru Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last as e consequence of) Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tohacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? 24a. Was an autopsy performed? 21/No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 MER/Outpatient 3 DOA 27. Menner of Death 1 2 Neturel 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and menner steted.

Examiner the death certificate be executed and Box 68760. physician Physician/Medical Records, P.O. þ Completed certificate Division of Vital or Attending Physician: Be After death. after deatl Hospital

Physician

/Medical

Examiner

Director

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**Funeral** 

Director

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'natural', or

Pages 1 and 2 should be mportant: If item 27 is marked

**Physician** /Medical

Examiner

Certification: To within 24 hours after To the Funeral Direcompletely filled in 5 29a. Certifier Medical To the I within 2

State

**DHMH 16 Ray 6/95** 

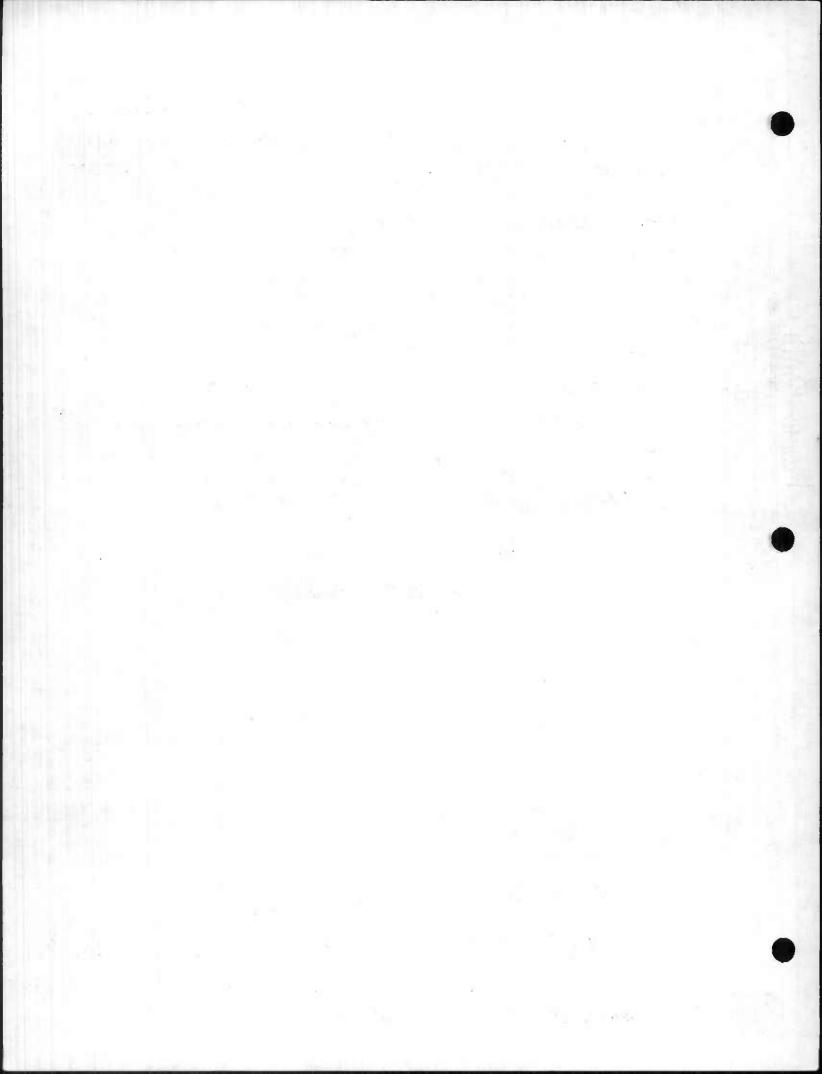
Registrar

Dete filed (Month, Dey, Year) JAN 2 0 1999 32. Fegistrar's Signeture

th (Item 23a) (Type, Print)

Franklin Quare Drive Baltimore

29d. Date signed (Month, Day, Year)



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Item: 20c per F.H G-767 1/20/99 reb Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day 14, 1999 9:16 A.M. CHRISTINE DEVRA SLY 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) ANNAPOLITAN NURSING FACILITY ANNAPOLIS If Under 24 Hrs. 8. De ANNE ARUNDEL If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) 1 M 4 F Months Days Hours Min. 220-07-1201 86 Yrs. JUNE 27,1912 MARYLAND Usual Residence of Decedent 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ◯ No MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 ARCHWOOD AVENUE 21061 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CLERICAL WORKER INSURANCE COMPANY 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) MARY SANNER CHRISTIAN CHURCH 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. informent's Neme/Reletionship (Type, Print) CHRISTINE D. COLEHOUSE (DAUGHTER) 50 ARCHWOOD AVENUE - GLEN BURNIE, MARYLAND 21061 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition BROOKLYN PARK 1 N Burial 2 □ Cremation 3 □ Removal from State CEDAR HILL CEMETERY 1/18/99 GLEN BURNIE, 4 ☐ Donetion 5 ☐ Other (Specify) MARYLAND 21. Signature of Funeral Service Licensee 22, Name and Address of Fecility HUBBARD FUNERAL HOME, INC. 23a. Pert l'Anter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate Approximate Intervel Between Onset end Death Immediate Cause (Finel diseese or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 28. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Nother (Specify) ASS: Seed Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

The law requires that the death certificate be executed

Attending Physician:

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show

I is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be

other t

permit. Pages Department of Important: If It eny injury or o

Pages 1 and 2 should be filed within 72 hours after death nant of Health and Mental Hygiena.

At: If Item 27 is marked other than "naturel; or Items 23.

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

the Maryland

Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical 98 980 signed by the a d be detached t by

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To

Certification:

Medical

is certificate has director, page 2

this funeral

Aftar

after deat Director:

To the Hospital or Attention 24 hours after dear To the Funeral Director completely filled in by the

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1□ Yes 2□ No 27. Manner of Death

5 Pending Investigation

6 Could not be determined

28a. Date of Injury (Month, Dey Year)

28h Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28d. Describe how Injury occurred

281. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

4 | Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner ss stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

LIVING

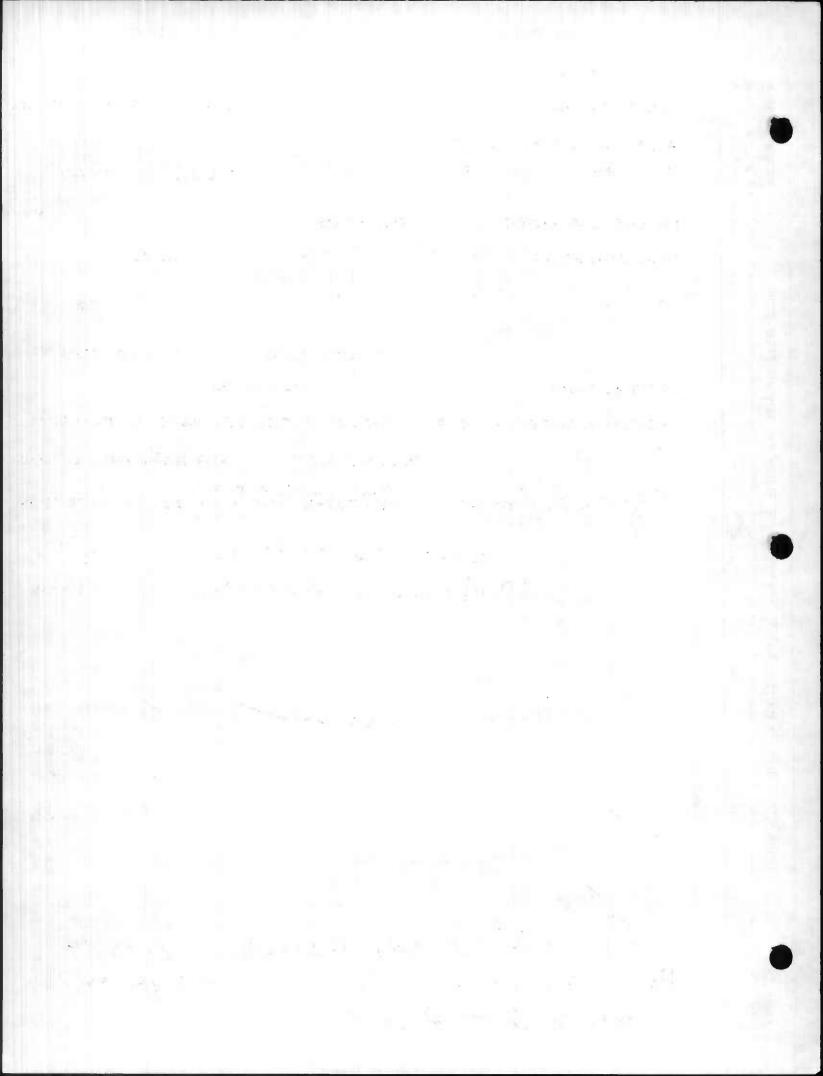
30 Name end address of person who completed cause of death (Item 23a) (Type,

mo

31. Date filed (Month, Dey, Year) State Registrar

JAN 2 0 1999

32. Registrar's Signature



1. Decedent's Name (First, Middle, L.			Certificate	01	Dodan	2. Date of Dec			3. Time of Death	
Vicktorianna Stiim						Month Januar	Dey 14. 1	Year (OC)()	10:05 P.1	
4a Facility Name (If not institution, give street and number)  4b. City, Town, or Li										
							Carr	011		
			Months	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.			8. Date of Birth (Month, Day, Year)		Birthplace (State or Foreign Country)	
		62	TIS.			2-24-	1936	Es	stonia	
10a. State 10b. County		10c. City, Town	n or Location						10d. Inside City Limits	
Maryland Carrol	1 Co	West	minster						1 ☐ Yes 2 No	
10e. Street and Number	1 00.	1 11000		Code			10g. Citizen of	Whet Cou	intry?	
600 Poole Road	i			211	57		Un	ited	States	
11. Marital Status	12. Wes Decedent	Ever in U,S.				city Yes or No-	- 14. Ra			
1 Never Merried 2 Merried	1 ☐ Yes 2 🔯							vvisite, etc.		
3 ଔ Widowed 4 □ Divorced	Year or Dates:		TEL TES ZIO SPECIF.				Specii	y.	White	
15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Usual (Give kind of work	Occup k done	pation during most of working	g	16b. Kind of 8	usiness/Industry		
Elementary/Secondary (0-12)			Inte. DO NOT use retired				Gonor	ntons		
12 2			Clert							
							Walder Curra	110)		
		19h	Meiling Address	/Street			er City or Town	State 7	in Code)	
									21009	
20e Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or To										
1 Burial 2 Cremetion 3 Removel from State							on I	Manuland		
100 100 100 100 100 100 100 100 100 100										
Micaude !	awast.	Gariapp								
		d the death. Do r	1						Approximate	
shock, or heart feilure. List only	one cause on each li	ne.						1	Onset end Deeth	
Immediate Cause (Finat	COMPINED	DRIIG AND	ALCOHOL IN	TOY	TCATION			1		
resulting in death)	a. CONDINED			10/12	2 0711 2 014					
Sequentially list conditions,  Due to (or as a consequence of):										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
that initiated events resulting in death) Last Due to (or as a consequence of):									Total Control	
	d									
Part It. Other significant conditions	contributing to death b	out not resulting in	the underlying ca	iuse gi	iven in Part I.	23b. Did 1	tobacco use co			
						10	Yaa 2□ No	3□ Pre	obably 4 🗆 Unknow	
							an autopsy	24h V	Vere autopsy findings	
						perfo	an autopsy amed?	a	vailable prior to ompletion of cause	
							of			
									/	
							Yes 2□No	,1	Yes 2□ No	
25. Was case referred to medical examiner?	Hospitel:			O	26. Place of Death	(Check only o	one)	1		
	Hospitel: 1 ☐ Inpatie		tpatient 3 DO	A Ott	ther: 4 Nursing Hor	(Check only one 5 Residue)	one)			
	4a Facility Name (If not institution, git Carro]. J. County G. S. Social Security Number 212-34-0414  Usual Residence of Decedent  10a. State 10b. County  Maryland Carro]  10e. Street and Number 600 Poole Road  11. Marital Status  1 Never Merried 2 Merried 3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last Hendrik Roosi  19a. Informant's Name/Relationship Mrs. Aili Kreek  20a. Method of Disposition  1 Burial 2 Mcremetion 3 I 4 Donation 5 Other (Specify only highest gr  21. Signature of Funeral Service Lice Middle, List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	4a Facility Name (If not institution, give street and number) Carrol. I. County General. Hos 5. Social Security Number 6. Sex 212-34-0414 1 M 2 M F 7. Ag 122-34-0414 1 M 2 M F 7. Ag 1234-0414 1 M 2 M F 7. Ag 124-34-0414 1 M 2 M F 7. Ag 125 M 2 M 2 M F 7. Ag 126 M 2 M 2 M F 7. Ag 127 M 2 M F 7. Ag 128 M 2 M 5 M 2 M F 7. Ag 129 M 2 M 5 M 2 M 5 M 2 M 5 M 2 M 5 M 5 M 5	4a Facility Name (If not institution, give street and number)  Carrol J. County General. Hospital.  5. Social Security Number  212-34-0414  Usual Residence of Decedent  10a. State  10b. County  Maryland  Carrol I Co.  West  10c. City, Tow  Maryland  Carrol I Co.  West  10c. Street and Number  600 Poole Road  11. Marital Status  1 Never Merried 2 Merried  3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12. Wes Decedent Ever in U.S. Armed Forces?  1 Yes, Give  Yes, Giv	Land   Land	Land   Land	4b. City, Town, or Loc Carrol.J. County General. Hospital  5. Social Security Number 212-34-0414  Usual Residence of Decedent 10a. State 10b. County Maryland Carroll Co.  10c. City, Town or Location Westminster 10c. Street and Number 600 Poole Road 11. Marital Status 11 Never Merried 12 Merried 13 Wiscoedent's Education 15. Decedent's Education 16. Steet or Dates: 15. Decedent's Education 17. Fether's Name (First, Middle, Last) Hendrik Roosiorg 19c. Informant's Name/Relationship (Type, Print) Mrs. Aili Kreek (sister) 10. State 10. Merried Sociality (Sister) 11. Marital Status 12. Wes Decedent Ever in U.S. 13. Was Decedent's Hispanic Origin's (Specify) 11. September of Dates: 15. Decedent's Education 16. Decedent's Last Occupation 17. Fether's Name (First, Middle, Last) Hendrik Roosiorg 19e. Informant's Name/Relationship (Type, Print) Mrs. Aili Kreek (sister) 10. Melling Address (Street and Number or Rura 11. Signature of Funeral Service Licensee Michael E. Canapp 12. Signature of Funeral Service Licensee Michael E. Canapp 12. Signature of Funeral Service Licensee Michael E. Canapp 12. Sequentially list conditions, a any, leading to immediate cause. Enter Underlying that initiated wereins 14b. County Min. 15c. City, Town or Location Westminster 10c. City, Town or Location Westminster 10t. City, Town or Location Westminster 10t. City, Town or Location Westminster 10t. City, Town or Location Westminster 10t. City, Town or Location Westminster 10t. City, Town or Location Westminster 10t. City, Town or Location Westminster 10t. City, Town or Location Westminster 10t. City, Town or Location Westminster 10t. City, Town or Location Westminster 10t. City, Town or Location Westminster 10t. City Town or Location Westminster 10t. City Town or Location Westminster 10t. City Town or Location Westminster 10t. City Town or Location Westminster 10t. City Town or Location Westminster 10t. City Town or Location Westminster 10t. City Town or Location Westminster 10t. City Town or Location Westminster 10t. City Town or Location Wes	Vicktoriana   Stim   Januar	Vicktorianna Stiim  4s Facility Name (if not institution, pive street and number)  Carrol.J. County General. Hospital  5. Social Security Number 212-34-0414  10 M 20 F 6. Sex 20 F 6. Sex 10 M 2	Vicktorianna Stiim   January 14, 1999   See Facility Name (in or institution, give street and number)   4b. City, Town, or Location of Death   Carrol J. County General. Hospital.   Westminster   Carrol J. Social Security Number   6. Sax   7. Age (in yrs. last birthday)   Morths   Days   Hunder 24 Pk.   a Date of Birth   Days   Hours   Min.   Days	

To the Hospital or Atlandi within 24 hours after death To the Funeral Director: completely filled in by the f

3 ☐ Suicide 4 ☐ Homicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 600 POOLE RD., 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) WESTMINSTER, MD.

29a, Certifier (Check of one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signy

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 15, 1999

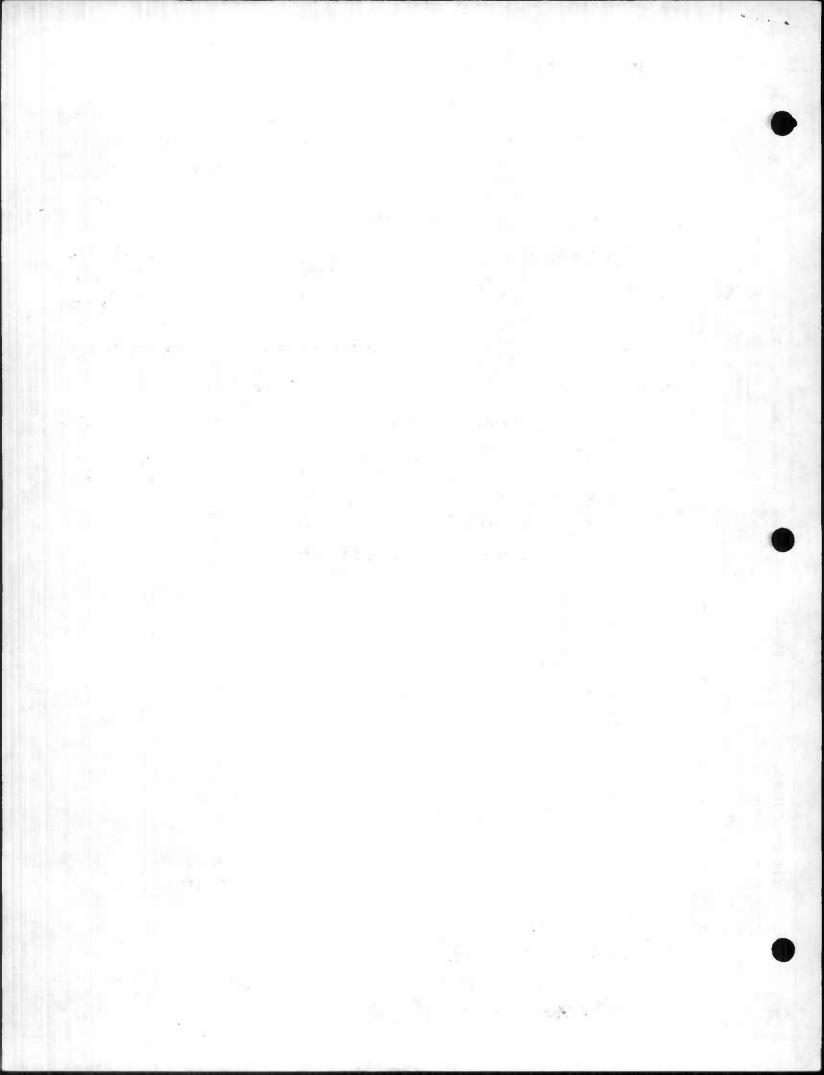
and address of person who completed cause of death green 23a) (Type, Print)

Afth (Determine)

Penn Stress: Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

State Registrar

Medical Certifica



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Day John Thomas Shultz 15, 1999 4:33 PM JANUARY 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Joseph Medical Center Towson Baltimore 8. Data of Birth (Month, Day, Year) Aug. 2, 1933 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (Stata or Foreign Days Delaware 1 GM 20 F Months Hours 65 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? 4 Forest Ridge Court 21093 U.S.A. 12. Wes Decedent Ever in U,S.
Armed Forcas?
tolyes 2 one
if Yas, Giva
Yaar or Datas. Orea 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yas, specify Cuban, Mexican, Puerto Rican, atc.)

1 Yas 2 No Specify:

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)

4 Forest Ridge Court

22. Name and Address of Facility

(Operations)

Beatrice

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)

Manager

20b. Plece of Disposition (Nama of cematary, cramatory or other place)

complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, but only ope-cause on each line.

ASPIRATION PNUEMONIA

Due to (or as a consequence of)

Dua to (or as a consequence of):

Dua to (or es a consequance of):

FIBRILLATION

CREBROVASCULAR ACCIDENT

28a-t show b Berns 23a "natural", or Baltimore, Maryland 21215-0020 reportant: If them 27 is marked other Pages 1 8

**Physician** 

/Medical

Director

**Physician** /Medical Examiner

Box 68760

P.O.

Records,

of Vital

Division

the burial-transit and for use as signed I page 2 has certificate Hospital or Attending Physician: director, this After death. Director: A To the Hospital or within 24 hours at To the Funeral Di completely filled in

Examiner Physician/Medicai h Completed Be Medicai Certification: To 29a. Cartifiar 29b. Signatura and titla of certifia

**Examiner** Saint 5. Social Security Number **Funeral** 221-20-2537 Usual Rasidance of Decedant 10a. State Director Maryland 10e. Street and Number Funeral 11. Marital Status 1 Nevar Married 2 Namied ğ 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grade completed) Elementary/Secondary (0-12) 12 Yrs. 17 Fathar's Nama (First Middle Last) Be Thomas John 19a, Informant's Name/Ralationship (Type, Print) Mrs. Twila J. Shultz/Wife 20a. Mathod of Disposition 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Ramovel from Stete 4 Donation 5 Mother (Specify) Intombment Gardens of Faith Mauso. 1/19/99 21. Signeture of Funeral Service License CE 23a. Part1. Enter the different shock, or haart failure. Immediata Causa (Final diseasa or condition rasulting In death) Sequentially list conditions, if any, laading to immadieta causa. Entar Undarlying Causa (Diseasa or Injury that initiated avents rasulting in death) Lest Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. GLIOBLASTOMA MULTIFORME 25. Was casa rafarred to medical axaminar? 1 Yes 2 No 27. Manner of Daath 1 Natural 2 Accident 5 Panding

31. Deta filed (Month, Day, Year) State JAN 1 9 1999 Registrar

3 Suicide

4 Homicida

hukla

28a. Data of tnjury (Month, Day Year)

College (1-4or 5+)
2 yrs.

ATRIAL

Shultz, Sr.

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Tima of

Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

29c. License number D48050

28c. Injury at Work?

1 Yes 2 No

10 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29d. Data signed (Month, Day, Year) 199

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Black, White, etc.

16b. Kind of Business/Industry

Chevron

Timonium, Maryland 21093

20c. Location - City or Town, Stata

Overlea, Maryland

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

1050 York Road

Approximata Interval Between Onset and Death

4 DAYS

1 MONTH

MONTH

24b. Were autopsy findings available prior to completion of cause of death?

1 Yas 2 No

18. Mother's Name (First, Middle, Maiden Sumame)

Ruck Towson Funeral Home, Inc. Towson, Md. 21204

Schafer

24a. Was an autopsy performed?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

1 Yas 2 No

28d. Describe how injury occurred

White

30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

investigation

6 Could not be datarmined

7601 OSLER DRIVE, TOWSON, MD 21204 PRASHANT SHUKLA, M. D.,

32. Registrer's Signatura

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** SCOTT RUTH 00:45 ANUARY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner HOPKINS tOSPITAL DALTIMORIE If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday)
Yrs. # Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
 Country) **Funeral** Months Hours 10 M 25 F 705-12-267 a Usual Residence of Decedent Director eptember 07,1910 MARYland 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show Yes 2□No Baltimore Director 4ARyland none 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Street Holbrook 21202 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 25 No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Saltimore, Maryland 21215-0020 by American 3 Widowed 4 □ Divorced "natural", Completed 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) OWN Home Homemaker permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Itam 27 is married other that any Injury or other traumaite avens 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Skinner HORROD 31/13 John 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Street 1422 Holbrook battiniose, Md 21202 Bendella Sewand Drughe 200 Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State ery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) HARCHAND Zion 22. Name and Address of Facility DARRY M. WALLACE FUNDEN Sorare 21. Signature of Funeral Service Licenses 3405 W. FRANKIN Street Battimore, MARYBAD welve 23a. Part — Efficiency e disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bright feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final neumonia disease or condition resulting in death) **Examiner** Due to (or as a consequence of): ementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): Records, P.O. Box 68760, attending physician Physician/Medical the Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown obstructive Dulmonary disease 8 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 2/2/10 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificat completely filled in by the funeral director, I 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) edical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 601 North Wolfe

**DHMH 16 Rev 6/95** 

State

Registrar

Baltimore MD 2128

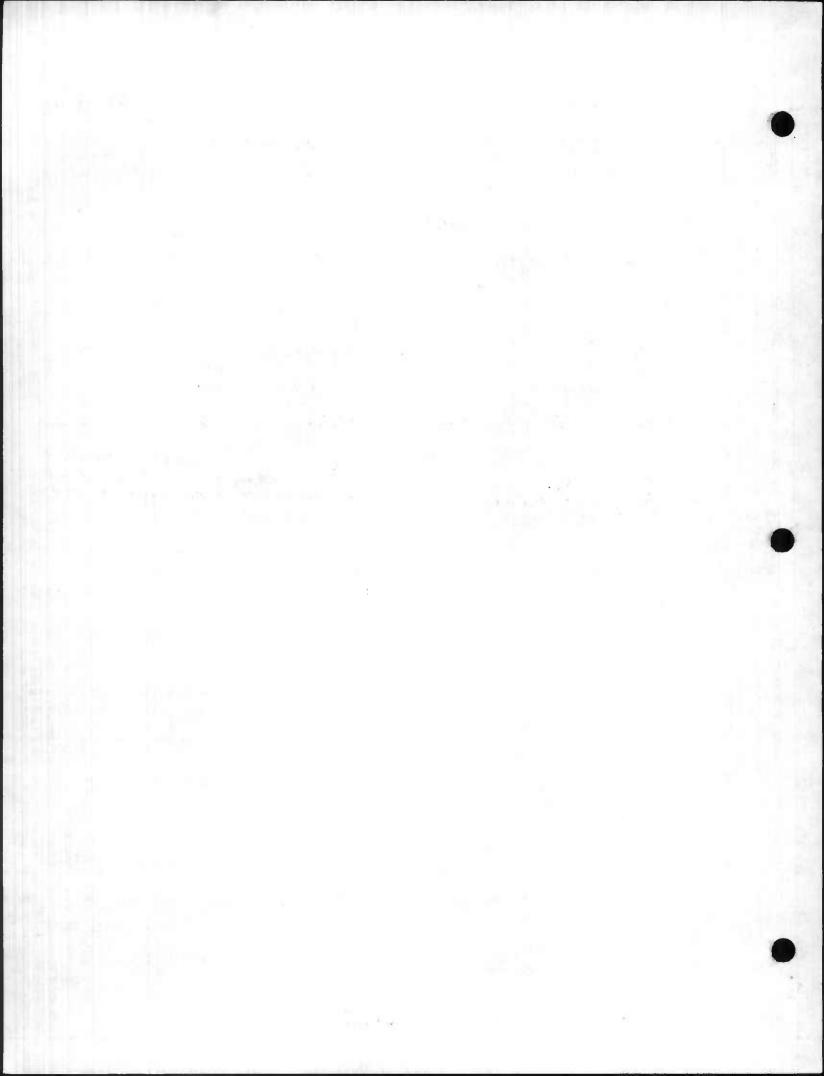
MD

32. Registrar's Signature

DCKERD

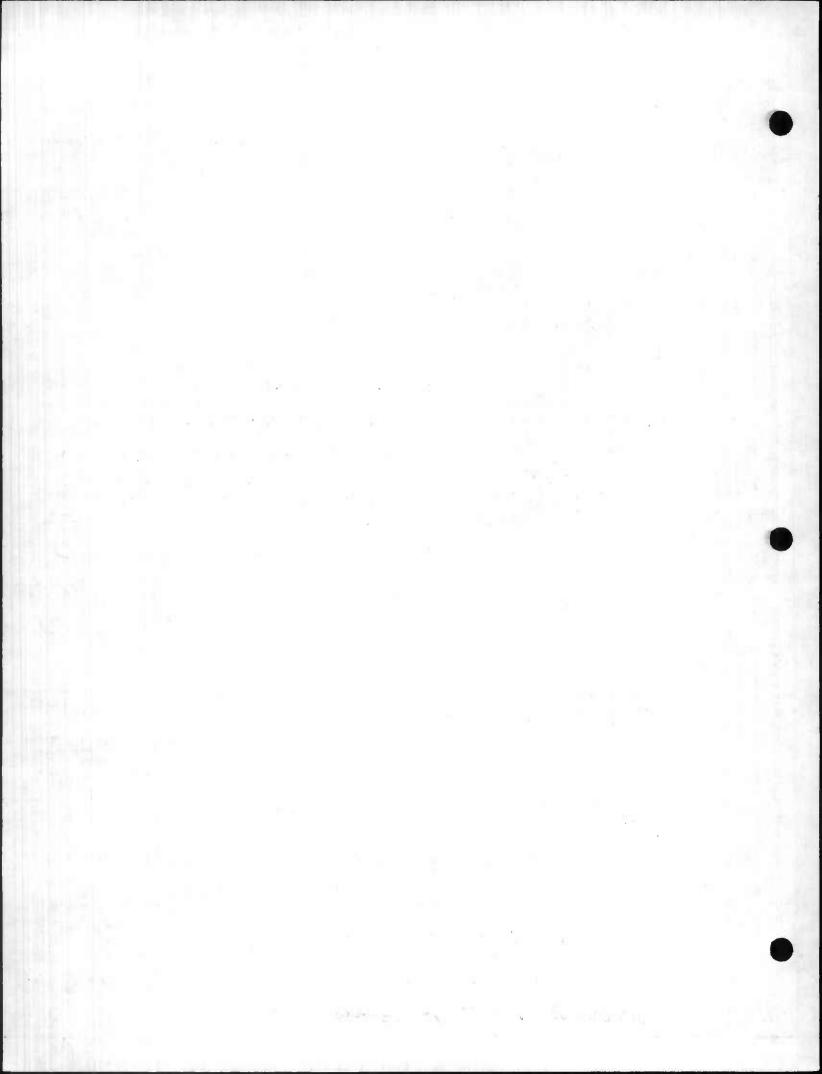
31. Date filed (Month, Day, Year)

JAN 2 0



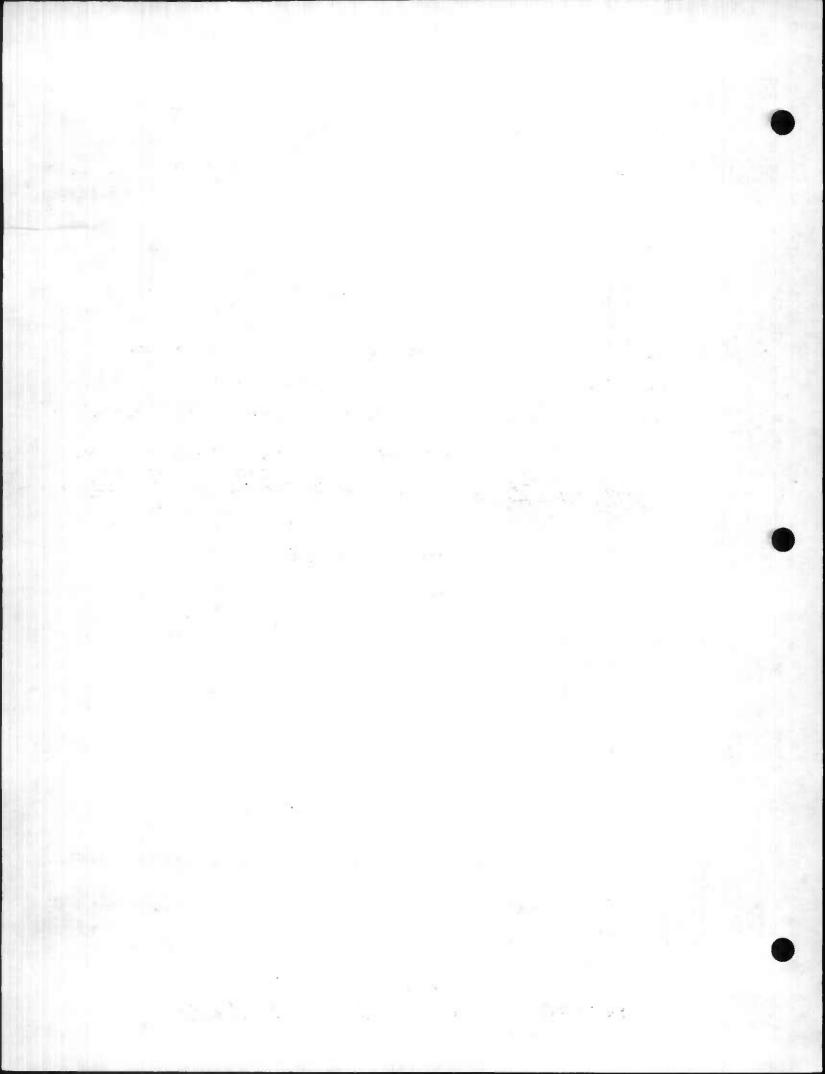
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 45 RUBEN 3 JAN /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS BALTIMONE ELDERCANE RANDAUS TOWN
If Under 24 Hrs. | 8. Date of Birth 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1**X**) M 2□ F Months Hours 062 Yre Director 10, CANADA Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow MD N/A BALTIMORE 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tema 23a or APT. B-6 3629 GLENGYLE AVENUE 21215 U.S.A. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married 1 1 Yes 2 No If Yas, Giva Year or Dates: 'netural', or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: WWII Specify WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWNER PRINTING permit. Peges 1 end 2 should be flie Department of Health end Mental Hy Important: if Itam 27 ia marked othe any injury or other traumatic avant page. 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY UNKNOWN SHAFFER RACHEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) APT • B—6 19a. Informant's Name/Ralationship (Type, Print) SYLVIA SHAFFER / WIFE 3629 GLENGYLE AVENUE - BALTIMORE, MD 20b. Place of Disposition (Name of cematary, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Remoyal from State BALTIMORE HEBREW CEMETERY 1/15/99 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Educati Service Cloning 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final tobe Kinner disease or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner sections or Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DEPENDENT JUCIN Box 68760. Physician/Medical the Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 ☐ Yes 2 ☐ No signed be del p Records, 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yas 25 No 1 Yes ZINO certificate Division of Vital Mospital or Attanding Physician: 124 hours after death.
 Funeral Director: After this certifical letely filled in by the funeral director, p. 25. Was case rafarred to made examiner? 26. Placa of Death (Check only one) Other: Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending investigation 1 Yes 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the To the 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CREENINEE ND 1 JAN 20 1999 Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 15, 1999 Mary E. Schmidt 12:00 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Rossville Rosedale Baltimore 7 Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1□M 2□¥ Deys Months Hours Yrs. 219-10-5400 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Rosedale MD Baltimore 1 Yes 2 No "natural", or herne 23a or 28a-f 101. Zip Code 27 10e. Street and Number 10g. Citizen of What Country? ä 6600 Ridge Road U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Merital Status hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Merried White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 permit. Pages 1 and 2 should be file Department of Health and Montal Hy Important. If them 37 is marked oths any injury or other trainmatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) å Lottie Davis Roth Louis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 Councilman Avenue Baltimore, Maryland 19e. Informent's Neme/Relationship (Type, Print) 21206 Schmidt/Son George A. 20b. Piece of Disposition (Name of 20c. Location - City or Town, Stete 20e. Method of Disposition Date ematory or other place) Commetery, crematory or other place)
Balto./Washington Cremet. 1/20/99 Laurel, Maryland 1 ☐ Burial 2 12 Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility John C. Miller Inc. 21. Signature of Furnary Service Licenses 6415 Belair Road Baltimore, 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examine physician and the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as e consequence of) thet initieted events resulting in death) Last 98 P.O. Pert li. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Dtd tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Onknown of Vital Records. by page 2 ahould t 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Meture! 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? Division Hospital or Attending 5 Pending investigation Injury death. To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 2 ☐ Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edical 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Qate signed (Month, Day, Year) who completed cause of death (Hem 23a) (Type, Print) IVO 04 31. Date filed (Month, Day, Year) 32. Registrer's State Registrar



99-0252-510

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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State of Maryland / Department of Health and Mental Hygiene \

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ROSALYN Certificate of Death TOWLES 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day Year **Physician** ROSALYN TOWLES JANUARY 16,1999 9:56P.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LIBERTY MEDICAL CENTER BALTIMORE 8. Data of Birth (Month, Day, Year) JULY 4, 19 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
BALTIMORE, MD. 5. Social Security Number UNK 6. Sax 7. Age (In yrs. last birthday) **Funeral** Months Hours 43 Yrs. Director Usual Residence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Directo MARYLAND BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code terms 23a or 2523 W. LANVALE STREET. 21216 Funeral 12. Was Decedent Evar in U.S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. hours efter 1 Nevar Married 2 Merried 1 ☐ Yas 2 ☐ XNo N Yas, Giva natural, or Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: AFRO. AMERICAN à 3 ☐ Widowed 4 ☐ Divorced Yaer or Detes: Completed 16a. Decedent's Usuat Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) DISABILITY DISABILITY permit. Peges 1 and 2 should be fits Department of Health and Mental Hy Important: if Item 27 is marked other enty Injury or other traumatic event, and. 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be SAMUEL TOWLES ELIZABETH TOWLES 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 3915 CLARINTH RD, BALTIMORE, SHARON TOWLES SISTER MARYLAND 21215 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 X Buriel 2 Cramation 3 Ramoval from Stata ARBUTUS MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) 1/23/99 ARBUTUS, MD. 21. Signatura of Funarel Sarvice Licensaa ESTEP BROTHERS FUNERAL SERVICE, P.A. LLOYD M. ESTEP

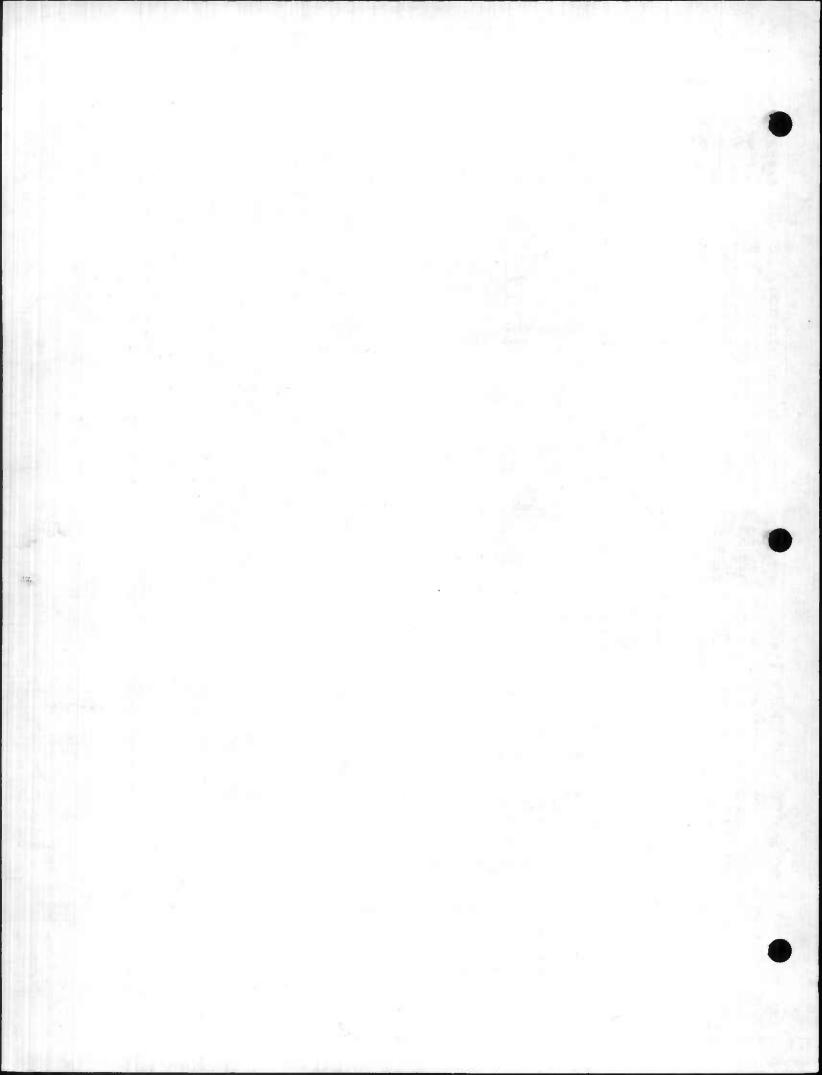
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| 1300 EUTAW P 1300 EUTAW PLACE, BALTIMORE, MARYLAND **Physician** a. Thermal Injuries complicated by conjective cardiac fuiture /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner physician and s the burial-transit Sequantially list conditions, if eny, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in daath) Last Box 68760 Physician/Medical Due to (or as a consequence of): P.O. 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 Yes 2 No 3 Probably 4 TUnknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Tyes 2 1 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Wes casa rafarred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 11 Yas 2 No Certification: To 28d. Describe how injury occurred Oress cought 27. Manner of Death 28c. tnjury at Work? 28a. Data of Injury (Month, Day Year) 28b. Tima of 1 Natural 5 Panding death. 1 Yas 2 No fire when she was some invastigation Unknown 2 Accident unknown Director: 6 Could not be datamined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) after 4 ☐ Homicide Euners aft
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 Setely filled in Unknown To the Hospital of within 24 hours a To the Funerel D Unknown 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) O.C.M.E. JANUARY 17, 1999 30. Neme and addrass of person who completed causa of death (ttem 23a) (Type, Print) forter David 111 Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 16 Rev 6/95

31. Data filed (Month, Day, Year)

32, Registrar's Signatura



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	/Medical Examiner	4a Facility Name (If not institution, g		nber)				4b. City, To	wn, or Lo	cation of Deat		y of Death		
	Examiner	Franklin Squar	e Hospit	al				Ros	svil	le	Bal	timor	e Co	).
	Funeral Director	5. Social Security Number 6. 212-26-7556	7. Age (In yrs. last	. last birthday) If Under 1 Year Months Days		Year Days			8. Date of Bir (Month, Da 3-7-19	th iy, Year) 129	Year) 9. Birthplace Country) Mary		(State or Foreign	
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	or 28s-f s be notified Director	10e. Street and Number 10f. Zip Code								10g. Citizen of What Country?				
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ary.	N pu	19a. Informant's Name/Reletionship	(Type, Print)		19b. Mailin	g Address	(Street	and Numbe	er or Ruri	al Route Numb	er, City or Town	, State, Zij	Code)	
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	Physician	23a. Part1. Enter the disease, or conshock, or heart leilure. List only	nplications that ca y ona cause <i>on</i> ea	used the death. I ach line.	Do not ente	er the mode	of dyir	ng, such as	cardiac (	or raspiretory a	rrast,	1		imate I Between and Death
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a(	Due to (or as	25	0274	N	DISA	2					
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	physician and s the burial-transit	Sequentially list conditions, if any, leading to immadiate	b	Due to (or as	a conseq	uence of):					-	1		
9	be buria	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	c											
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	at the death certi of by the attending etached for use a	Part II. Other algnificant conditions	contributing to dec	ath but not resultin	ng in the ur	nderlying ca	use giv	ven in Pert I	I. 23b. Did tobacco use contribute to the cause of de				use of death	
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	2 00	examiner?	Hospital: 1 🗆 In	patient 2 ER	/Outpatien	t 3 DO/	Oth	ner: 4 Nu	rsing Ho	me 5 Resi	dence 6 Ot	her (Speci	ity)	-
lon of	ath.: After the funeral	27. Manner of Death  1 Netural 5 Pending 2 Accident Investigation		f Injury n, Day Year)	b. Time of Injury	M 28	ic. Injui Woi	yat rk? Yes 2□		28d. Describe	how Injury occu	rred		

Division Medical Certification

To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: Attent completely filled in by the funeral

3 Suicide

29a. Certifier (Check only one)

4 Homicide

6565

29b. Signature and title of certifier

**DHMH 16 Rev 6/95** 

State Registrar

31. Date filed (Month, Day, Year)

JAN 1 9 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

N.CHALLES ST 5VINE 411 32. Registrar's Signature

28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

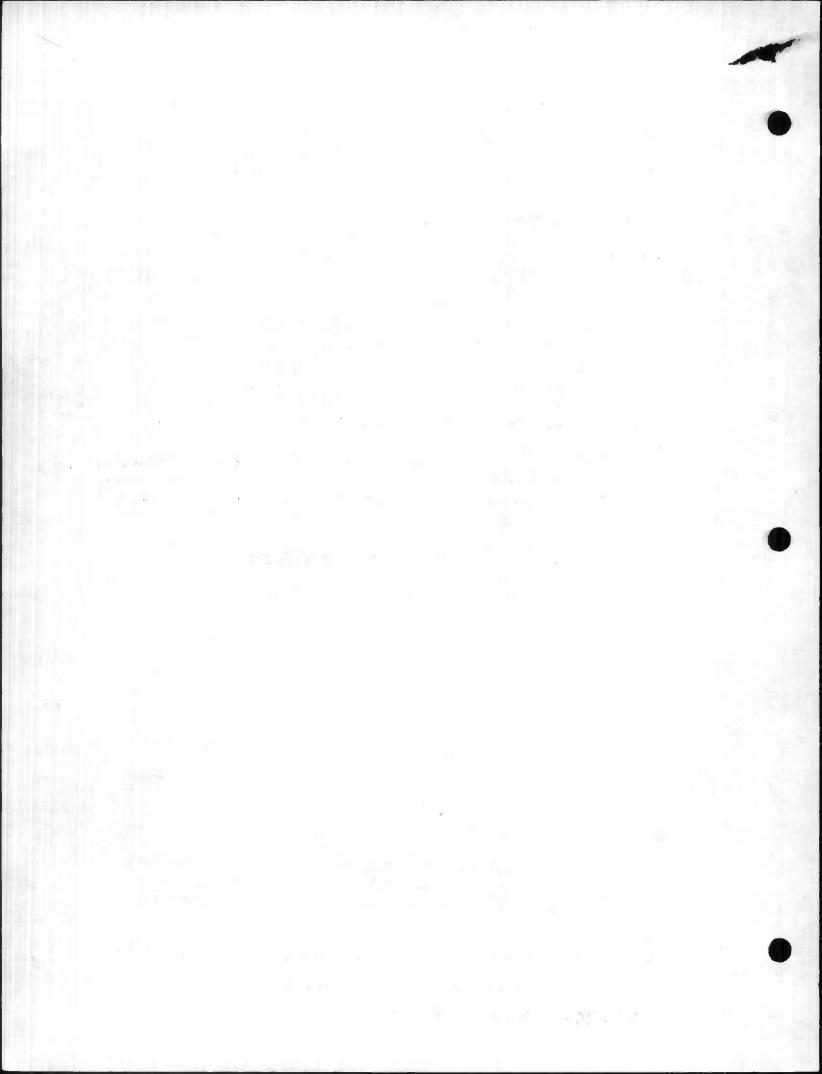
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1 Cortifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 00995 Certificate of Death Items: 8.17 per F.H G-768 2/1/99 reh 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** LEANDR URNER 1999 11:50am YARUARI /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LANCE MARYLAM TO MIZZINGAL 7. Age (In yrs. last birthday) If Under Months BAUTIMOLE MAY 9. Burthpa CITY 8. Dete of Birth MAY (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Deys Hours Min. 1 M 2 X F Director 083-09-4087 80 1918 New York Usuat Residence of Deceden the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 1X Yes 2 No Director New Jersev Hudson Co. Jersey City 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 07306 United States 9 Garrison Avenue 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: "natural", or items Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Bleck, White, etc. 72 hours after 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglane. Important: If item 27 is marked other than "nat any injury or other traumatic event, the Medical DRCS. (Give kind of work done during most of working life. DO NOT use ratired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Friedman Meyer Freidman Esther Locker 0 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Goldstein / Daughter 2348 Putnam Lane Crofton, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 1/17/99 Staten Island, New York Baron Hirsch Cemetery 21. Signature of Funerel Service Licensee Michael E. Canapp 22. Name and Address of Fecility 5305 Harford Road Mille Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finet HEMORRHAGE disease or condition resulting in death) Examiner Due to (or as e consequence of) Examiner physician and the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 edical Due to (or es e consequence of): Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by I 1 Yes 2 No 3 Probably 4 Unknown MYELOGENOUS LEUKEMIA Records, by 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed THROMBOCYTOPENIA completion of cause of deeth? paga 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital director, B 25. Wes case referred to medical axaminer? 28. Place of Deeth (Check only one) Hospitet: 1 Impatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this After thi 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 1 Natural Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred i or Attending P after death. I Director: After t 5 Pending investigation 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and dua to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) adays Mrs

State Registrar

**DHMH 16 Rev 6/95** 

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture

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JAN 2 0 1999

31. Date filed (Month, Day, Year)

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JANUARY 13, 1999

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Registrar

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CHARLES F. O'DONNELL, M.D. 31. Date filed (Month, Day, Year) JAN 2 0 1999

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Pegistrar'a Signature

Jonne

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 HAMLET HILL - BALTIMORE Docks

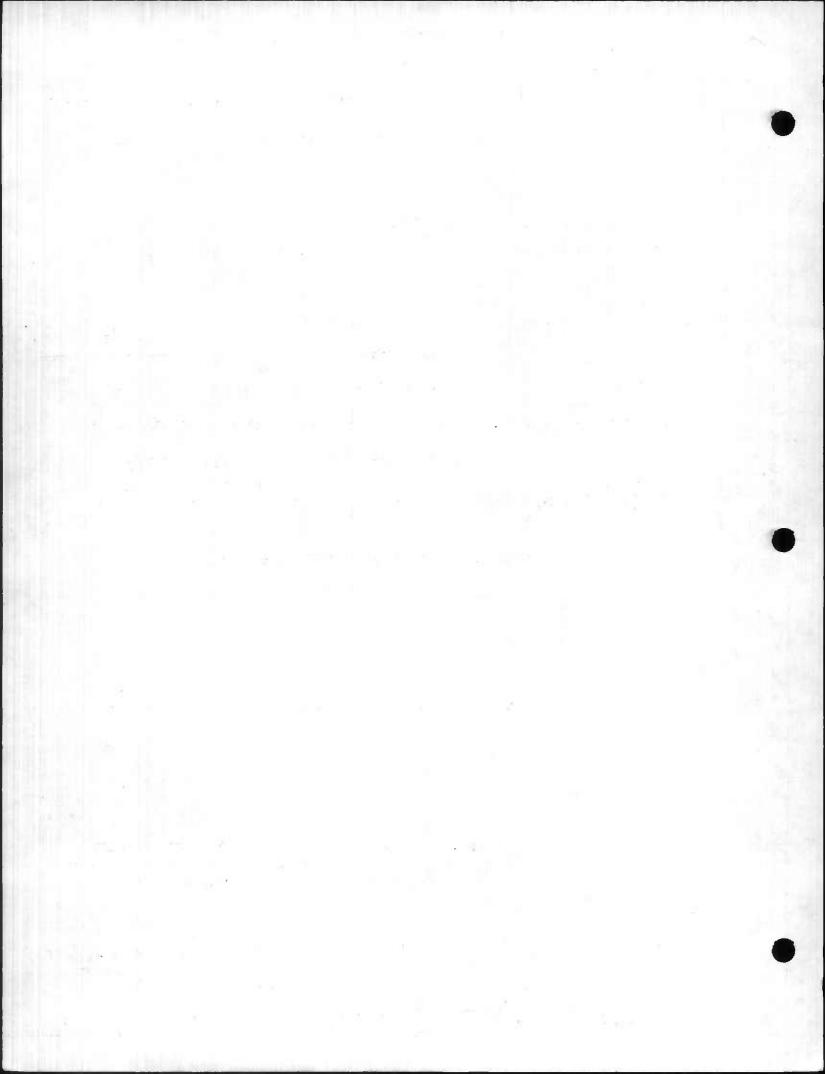
1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

MD

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Certification: 29a, Certifier

this Attending in 24 hours effect deeth. To the Hospital or within 24 hours eft To the Funeral Di completely filled in edical

Division of Vital

State Registrar

1XX es 2□ No 27. Manner of Death 1 Natural 2 Decident 3 ☐ Süicide 4 ☐ Homicide

25. Was case referred to medical examiner?

(Check only

29b. Signature.

5 Pending investigation

6 ☐ Could not be

Hospitel:

28a. Date of Injury (Month, Day Year)

1 Inpatient 2 ☐ ER/Outpatient 3 N DOA 28b. Time of Injury

284. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HICHUAY

28c. Injury at Work? 1 ☐ Yes

29c. License number

O.C.M.E

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

111 Penn Street, Baltimore, Maryland 21201

26. Place of Death (Check only one)

28d. Describe how injury occurred The INauto acado, 28f. Location (Street and Number or Rural Route Number City or Town, State) Wishs

Pes 2□ No

700 18. Continuing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ••• On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 No

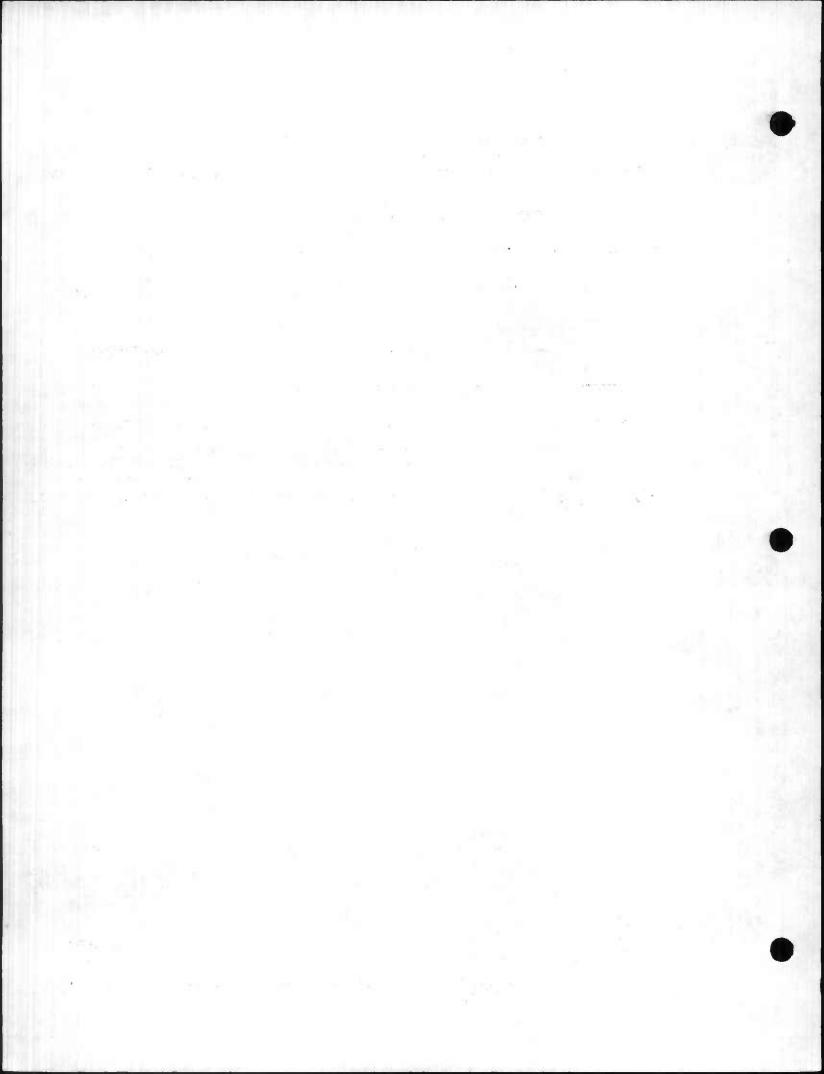
29d. Date signed (Month, Day, Year) JANUARY 15,1999

eted cause of death (Item 23a) (Type, Print)

wo LARON LOUKE 31. Date filed (Month, Day, Year) 1999

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32. Registrar's Signature



Examiner physician and the bunal-transit The lew requires that the death certificete be executed P.O. Box 68760. signed by the eld be detached for Division of Vital Records. ils certificate has I i or Attending Physician: after death. Director: After this certifica funeral rector: / To the Hospital or within 24 hours aft To the Funeral Di completely filled in

**Physician** 

/Medical

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Pages 1 end 2 should be filed within 72 hours after death with the Manyland and Ordellath and Mental Hyglene.
nati of Health and Mental Hyglene.
nati if iten 27 is marked other than "natural", or items 23a or 28a-f ahow

permit. Pages Department of Important: if it any injury or o

**Physician** 

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Certification:

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Baltimore, Maryland 21215-0020

1 Yes 2 No 27. Manner of Deeth Netural 2 Accident 3 Suicide 4 Homicide

29a. Certifier

State Registrar 29b. Signature end title of cartifier un

IAN 2

29c. License number 901

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

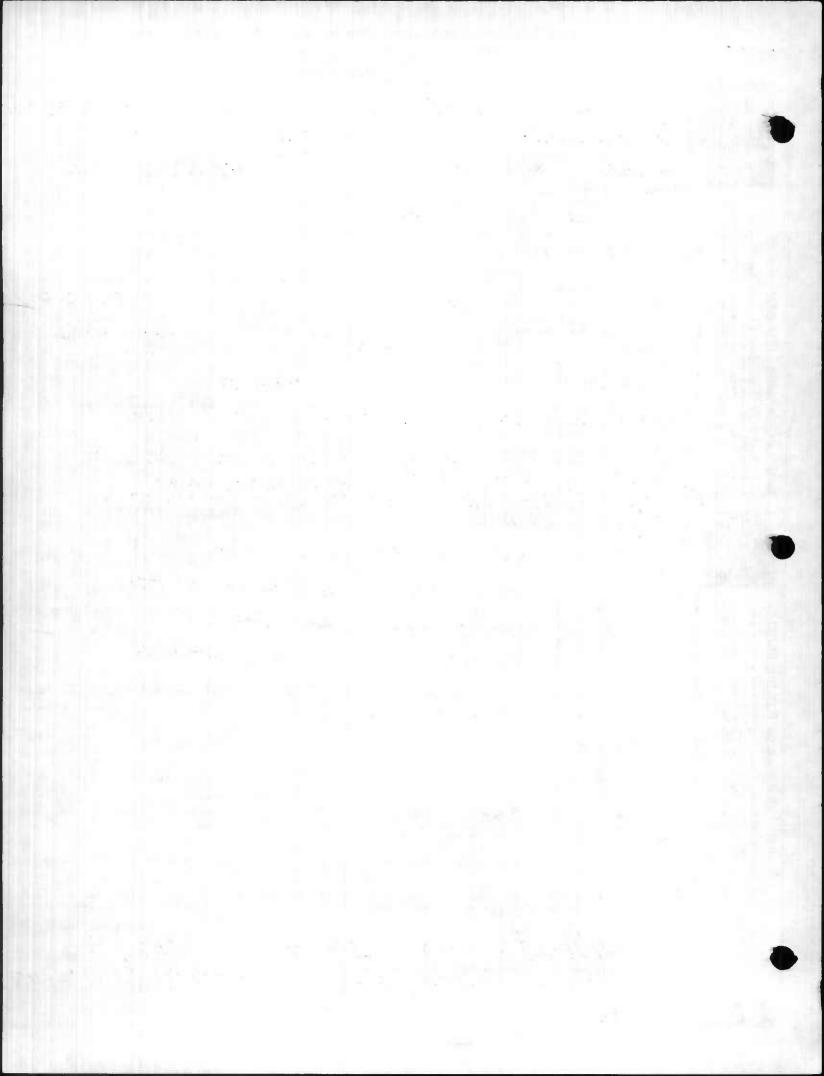
29d. Date signed (Month, Day, Year) MARYLANI

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) AMB ACH

Works 31, Date filed (Month, Day, Year)

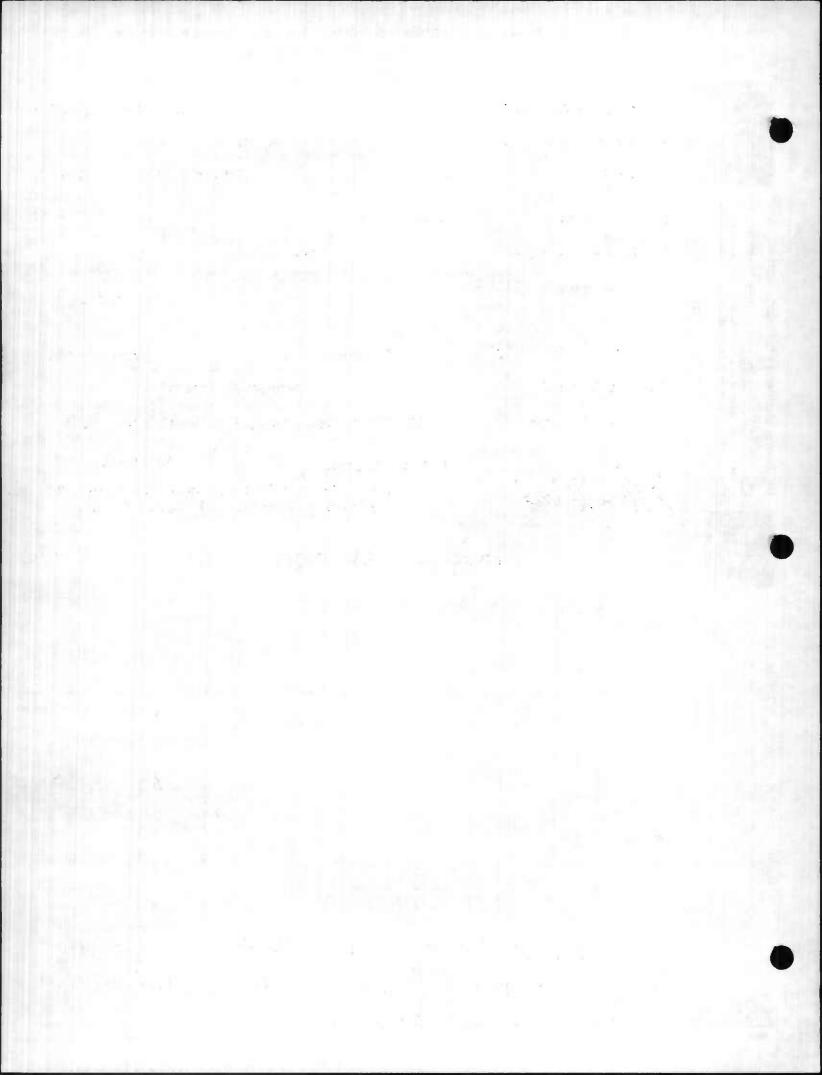
32, Registrar's Signature

DHMH 16 Bey 6/95



Please Type or Print in Biack Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** KARL DAVID JAN. 16, 1999 10:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 226 Thomas Manor Lane Forest Hill Harford If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** 1 M 2 F Deys Hours Yrs. 213-76-0642 32 25, FEB. 1966 Director Maryland Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Harford Forest Hill 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 226 Thomas Manor Lane 21050 USA Pages 1 and 2 should be filed within 72 hours after death near of Health and Mental Hygiene. Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Biack, White, etc. 11 Maritel Status 1 ☐ Yes 2 🕅 No if Yes, Give Yeer or Dates: 1 Never Married 2X Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Coilege (1-4or 5+) Elementery/Secondary (0-12) Builder Construction 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) William E. Wolf Dorothy M. Scharpf 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Diane Wolf - wife 226 Thomas Manor Lane, Forest Hill, Md. 21050 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1/21/99 1 X Buriai 2 Cremation 3 Removal from State Department of Important: If any injury or once. ò 5 Other (Specify) 4 Donation Baltimore, Md. Parkwood Cemetery 22. Name end Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 7250 Washington Blvd., Elkridge, Md.
List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,
List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in death) 8 years Examiner Due to (or es a consequence of): Examiner that the death certificate be executed sician and burial-trans Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): physician the burial P.O. Box 68760 Physician/Medicai Due to (or as e consequence of) 50 use a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed t Division of Vital Records, by 24b. Were autopsy findings evaileble prior to 24a. Was en autopsy performed? Completed completion of ceuse of deeth? has page 2 1 Yes 2 No certificate 2 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 🗷 Residence 8 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Yeer) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending 24 hours after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) and manner as stated. edicai (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner steted. To the within 2 To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 7007 30. Name and address of person who completed cause of death (item 23a) (Type, Print) , Johns Hopkins Qualogy, Balt. 418 N. Bond St. 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State Registrar

**DHMH 16 Rev 6/95** 

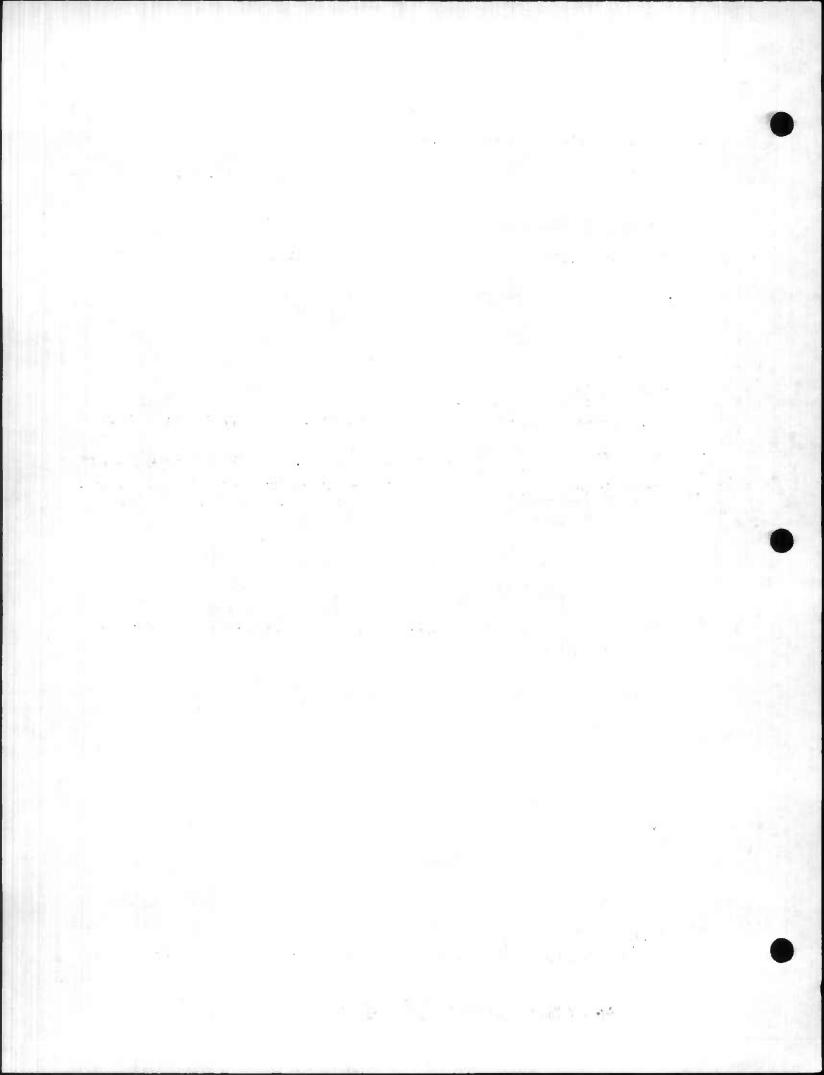


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State of Maryland / Department of Health and Mental Hygiene

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				Cei	tificate o	t Death		Reg	. No.		
hysician	Decedent's Nama (First, Middle		zabeth	Julia	Wane	k		Data of Death Month	Day	Yaar 199	3. Time of Death 5:25 AM
/Medical Examiner	4a Facility Name (If not institution			Ourra	wario	_	wn, or Location	7	4c. County		3.23 242
	Genesis Herit	age Merid	dan Elde	ercare		Dur	ndalk		Ва	ltimo	ore
uneral	5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Ye		24 Hrs. 8. [	Date of Birth Month, Day, Y	'ear)	9. Birthpl Count	ace (State or Foreign
rector	219-10-0911	1□M 2Д F	88	Yrs.				lov. 20			yland
<b>*</b>	Usual Residence of Decedent  10s. State  10b. County		10c. C	ity, Town or Lo	cation					110	Od. Inside City Limits
Exercise must be notified at	Maryland 10e. Street and Number	Baltimor			10f. Zip Code		dalk	100	. Citizen of V		1 ☐ Yes 2 ☑ No
1 10					Tot. Zip Cook		20				
era	7232 German H	_	cedent Ever in U	J.S.   13 V	Was Decedent o	21222 s Decedent of Hispanic Origin? (Specify Yes or N			United	a - America	
Funeral	1 Never Married 2 Marr	Armed F led 1 ☐ Yas	Forces?	'	f Yes, specify C	uban, Mexicar	n, Puerto Rica	n, etc.)		k, White, a	
by	3 Widowed 4 □ Divorced	If Yes, G Year or	Give T		1□Yes 2√E/N	lo Specify:			Specify	: 1	White
P	15. Deceden	's Education	4	16a. Deced	dent's Usual Occ	upation	at ad supplies	16	b. Kind of Bu	siness/Ind	lustry
Completed	(Specify only highes Elementary/Secondary (0-12)	T	(1-4or 5+)	life.	kind of work dor DO NOT use ret	ired)	n or working				
Con	8 Years			Hom	emaker					Home	9
Be	17. Father's Name (First, Middle,	Last)					er's Name (Fir			Θ)	
2	Frank Vrablic					I	Frances	Oswal	d		
	19a. Informant's Name/Relations Mrs. Bernadin		-		ng Address (Street)  O Wise A					State, Zip 2122	
	20a. Method of Disposition	٠٠٠		Place of Dispo	sition (Name of natory or other p	olace)	D	ate 20	c. Location -	City or To	wn, State
	1 Surial 2 Cremation 4 Donation 5 Other (S)		n State		f Faith		1/15/1	999	Baltim	ore,	MD
	21. Signature of Funeral Service	Licensee		22	Name and Adr	trace of Facilit	hv		Dundal	<b>և</b> т.	200
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n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.CHR	DUBTO	or as a consequence of as a consequence of a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a	ROTIC  Wence of):  RUCT	. CAR	PULL	SCUL DISEA LONAI	AR ISE 24 DI	SEASE	
Physician	Part II. Other algnificant condition	ns contributing to	death but not re	sulting in the u	nderlying cause	given in Part I	1.	23b. Did tob	acco une cor	ntribute to	the cause of death?
by Phy								1 🗆 Yee	2 □ No	3 Prot	pebly 4 Dunknown
Completed b								24a. Was an performe		ava cor	ora autopsy lindings ailable prior to appletion of cause death?
mo	MAG.							1 🗆 Yes	2016		Yas 20 No
	25. Was case referred to medical					26 Plans	a of Death (C/		-		200 20110
o Be	examiner?	Hospital:	Inpatient 2	ER/Outpatien	t 3D DOA	Other:/			са 6 Понь	ar (Snacih	()
-	27. Manner of Death 11. Natural 5 Pending 2 Accident investigati	28a. Date	of Injury onth, Day Year)	28b. Time of 28c. Injury at 2				tome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred			
Certification:	3 Sulcide 6 Could r determ	ned 200. Plac	ca of Injury - At I ding, etc. (Speci	nome, larm, str	eet, factory, office	>8		Location (Stre City or Town,	on (Street and Number or Rural Route Number Town, State)		
Medical Certifi	29a. Certifier 1 Certifyin	Physician: To the Examiner: On the I and ma	e best of my kno basis of examina nner stated.	owledge, death ation and/or inv	occurred at the vestigation, in m	time, date an y opinion, dea	nd place, and o ath occurred a	due to the cau t the time, date	se(s) and ma e and place, a	nner as st and due to	ated. the cause(s)
M	29b. Signatura and title of certified				29c. Lice	ense number		290	f. Date signed	d (Month, i	Day, Year)
1	Canand	1,1,6	1.010	· Ma	1 00	2710	8		11/12	18	8
W	30 Name and address of person	who completed cau	use of death (Ite	m 23a) (Type	Print)	1	0		113	1	
V	Sanualis	e Tue	111- 2	MA	relet	Vlace	e Be	Ati.	1010	MA	2/222
State	31. Date filed (Month, Day, Year)	1000 32.	Registrar's Sign	atura	1	11	,,,,	an in	nene		,
egistrar	JAN 19	1999	Depend	D.	pour	2					



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**Physician** 

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permit. Pages 1 and 2 should be fix Department of Health and Mental Hy Important: If them 27 is marked oth any Injury or other traumatic event.

72 hours after

Baltimore, Maryland 21215-0020

Box 68760

Records, P.O.

Division of Vital or Attending Physician: Directo

Funeral

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Examin Sequentially list conditions, if any, leading to immediate cause. Enfer Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical þ Completed

25. Was case referred to medical examiner? 1 Yas 2 No

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be 4 Homlcide

1 □ Yes 2 □ No 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated.

29b. Signefure and titla of certifier

29c. License number 28137

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29d. Date signed (Month, Day, Year)

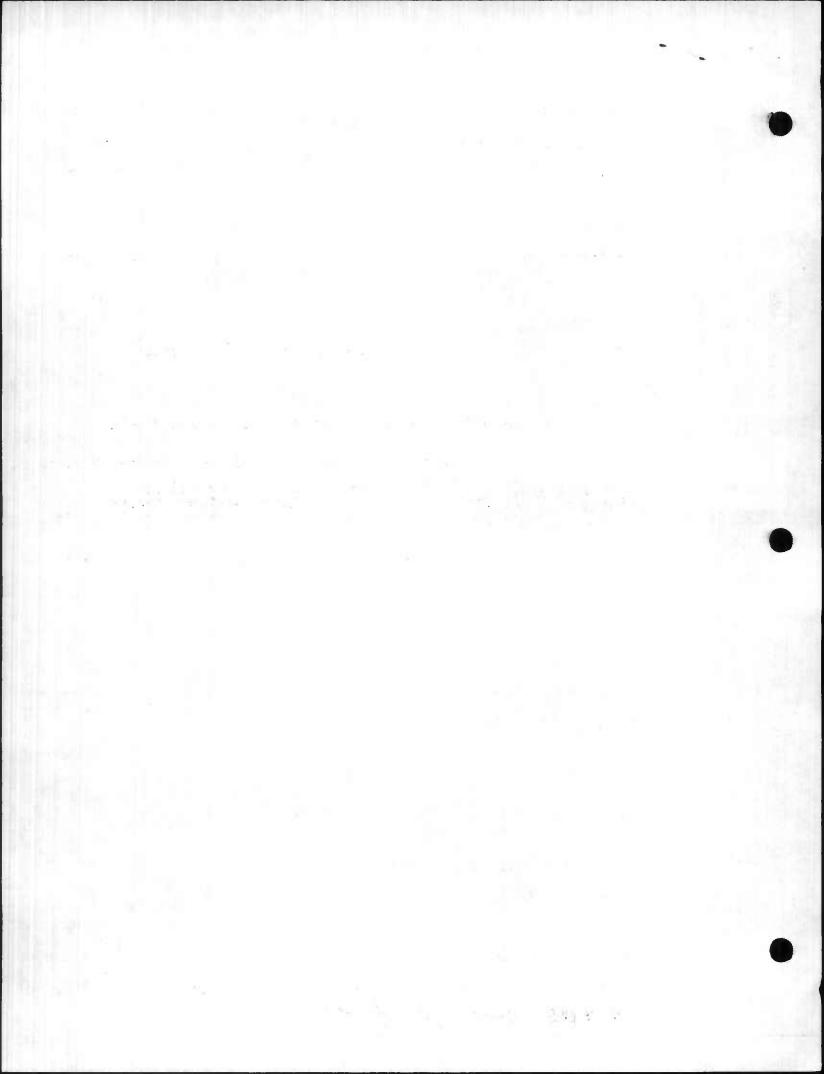
Howard S. Freeland

ochlaven 5601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud Salto

31. Date filed (Month, Day, Year) 32. Registrar's Signeture JAN 1 9 1999 oouts

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month George Milton 01 1999 Ward 1:35 pm /Medicai 4a. Facility Neme (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Broadmead Cockeysville

If Under 1 Yeer | If Under 24 Hrs. | 8. Data
Months | Deys | Hours | Min. | (Mor. Baltimore 5. Sociel Security Number 8. Data of Birth (Month, Dey, Year) Birthpiace (Steta or Foraign Country) 6 Sax 7. Age (In yrs. last birthday) **Funerai** 1 M 2□ F Yrs. Director 213-01-3883 83 Jan. 21, 1915 Md. Usual Rasidance of Decedant the Marysan r 28a-f show 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Director Md. Baltimore Cockeysville 10e. Street and Number 10g. Citizen of What Country? ò the Medical Examiner must be "natural", or Itama 23a 13801 York Rd. Apt. H12 21030 Funeral USA 12. Wes Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, atc. 72 hours after 1X Yes 2 No If Yes, Giva Yeer or Dafas:WW─II 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be that is Department of Health and Mental Hygies Important: if Item 27 is marked other the any Injury or other traumers. 12 CPA Bethlehem Steel Corp. 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Meiden Surnama) Be 2 Maurice Ward Martha 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Mrs. Elizabeth P. Ward/wife 13801 York Rd. Apt. H12 Cockeysville, Md. 21030 20b. Piace of Disposition (Nama of cematary, crematory or other piece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 (Other (Specify) Entombment Dulaney Valley Memorial 1/18/99 Timonium, Md. 22. Nama and Addrass of Facility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 Push. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shopp, or heart failure. List only one cause on each line. Approximata Intervel Batw Onsat and Death **Physician** /Medical Immediata Cause (Final concer of face disease or condition rasulting in daeth) Examiner Due to (dr es a consequenca of): Sequentially list conditions, if any, laading to Immadiata ceusa. Enter Underlying Cause (Diseasa or injury that initiated avents rasulting in daath) Last and Dua to (or es e consequence of) physician a Box 68760, Physician/Medical Dua to (or as a consequence of) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings avelieble prior to completion of causa of daath? Completed 24a. Wes en eutopsy performed? 2 DNO certificate 1 Yas 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes case referred to medical examiner? Be 26. Placa of Death (Check only ona) Othar: 4☑ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 BNaturai 5 Panding Invastigation 1 Yes 2 No 2 Accidant 3 ☐ Suicide 6 Could not be datermined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28a. Piaca of Injury - At home, ferm, streat, fectory, office building, atc. (Specify) 4 D Homiclde 1 Certifying Physician: To the best of my knowledga, dasth occurred at the time, data and piace, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, dasth occurred at the time, data end place, end due to the causa(s) and mennar stated. 29a. Certifian 29b. Signature and title of cartifier 29c. License number 29d. Data signed (Month, Day, Year) complated ceuse of deeth (item 23a) (Type, Print) RK RD., COCKEYSVILLE

Registrar

31. Data filed (Month, Day, Year) JAN 1 9 1999

32. Ragistrar's Signatura

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** 1999 07:35AM JAN ALBERT C JR. WOLF /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street end number) 4c. County of Death Examiner HOWARD GENERAL HOSPITAL COLUMBIA (OUNTY HOWARD 5. Social Security Number Birthplace (State or Foreign Country) Months Deys 1X M 2□ F 75 Yrs. 218-16-0063 June 7, 1923 Maryland Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d Inside City Umits 1 Yes XXNo Director MD Howard Columbia 10e. Street end Number 7075 Melting Shadows Lane 10f. Zip Code 10g. Citizen of What Country? 21045 U.S.A. Funeral 12. Wes Decedent Ever In U.S. Armed Forces? 1৯% Ses 2 □ No If Yes, Give Year or Detes: WWII 14. Rece - American Indien. Wes Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Married 2 Married 1 Yes 2 No White Specify: py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use ratired) College (1-4or 5+) Elementary/Secondary (0-12) Electronic Engineer NSA 18. Mother's Neme (First, Middle, Maldan Sumeme) 17. Fethar's Neme (First, Middle, Last) Albert C. Wolf, Sr. Della M. 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) n) P. O. Box 6785, Columbia, MD 21045

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dete 20c. Location - City or Town, State Patrick A. Jameson (Grandson) 20a. Mathod of Disposition 1 Burlet 2 □ Cremetion 3 □ Removel from Stete MD National Memorial Park 1/21/99 Laurel, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke FUneral HOme, Inc. 21. Signature of Funeral Service Licensee 5555 Twin Knolls Road, Columbia, MD 21045 23a. Part1. Entar tha disaase, or combilidations that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in daeth) DAY HEMORRHAGE INTRA CEREBRAL Due to (or es e consequence of): Examiner MALIGNANT MELANOMA 18 MONTHS Due to (or es e consequenca of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury Physician/Medical thet initieted events resulting in death) Last Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Ware autopsy findings aveilable prior to complation of cause of death? 24e. Was en eutopsy 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To 27. Magnar of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 28a. Data of Injury (Month, Dev Year) 1 Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, streef, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the causa(s) and menner as stated.

Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, and due to the cause(s) and manner stated. 29a. Certifian Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number

State

2 0 1999 Registrar

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30. Nema end addrass of person who completed causa of daath (Item 23e) (Type, Print)



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JAN 17, 1999

ELLICOTT CITY, MG 21042

**DHMH 16 Rsv 6/95** 

**Funeral** 

Director

worle

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryle Department of Health and Mentel Hydene. Important: If item 27 is marked other than "natural", or items 23s or 23s-f show any injury or other treumatic avent, its Maxical Examinet must be not a once.

**Physician** 

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Examiner

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To the Hospital or Attendir within 24 hours after death. To the Funeral Director; Af completely filled in by the fu

director,

The law requires that the death certificate be executed

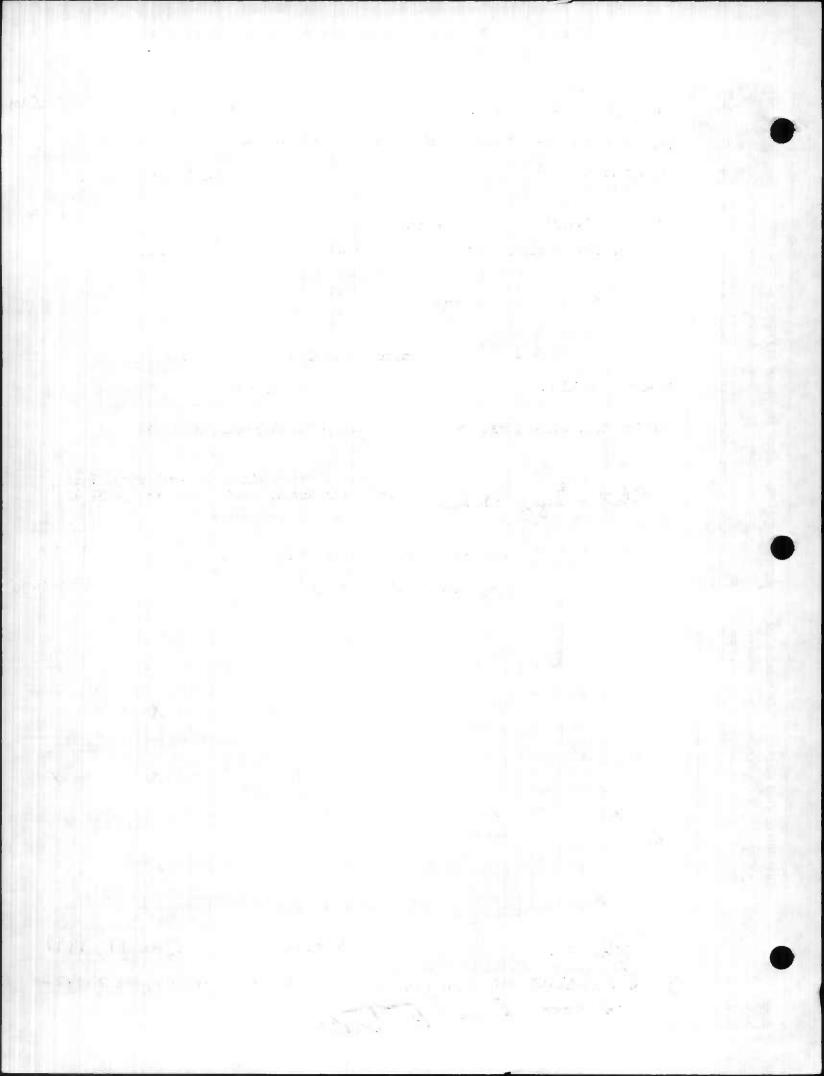
or Attending Physician:

death.

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0020

with the Meryland



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Anna M. Warth /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner St. Elizabeth Nursing Home Baltimore 8. Date of Birth (Month, Dev. Year)
March 9, 1914 Maryland If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours Min 84 Director 212-03-8191 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ebov treumstic event, the Medical Examinat must be notified at MD Baltimore Arbutus 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1822 Palo Circle 21227 Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Biack, White, etc. 1 X Never Married 2 Married Specity: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuai Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Retail 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) 12 should be fill h and Mental H Joseph Warth Anna Potye 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tre 5 Light Street, Suite 510, Baltimore, Maryland 21202 Arthur Drager, Eq. 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1/21/99 Baltimore, Maryland New Cathedral Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 Robert 23a. Part1. Enter the disease, or or more tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Ceuse (Finel diseese or condition resulting in death) /Medical Aspins tim Preumo Examiner Examiner Stron physician and s the burial-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to or as a consequence of): MARGALET Physician/Medical Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by t With a Pixutonens Feeling 3 Probably 4 Unknown 1 Yes 25 No by Division of Vital Records, 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? Completed completion of cause of death? certificata has 1 Yes 2 No 1 ☐ Yes 2 ☐ No i or Attending Physician: after death. Director: After this certific 25. Wes case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of Certification: 5 Pending investigation 1 Sevetural 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

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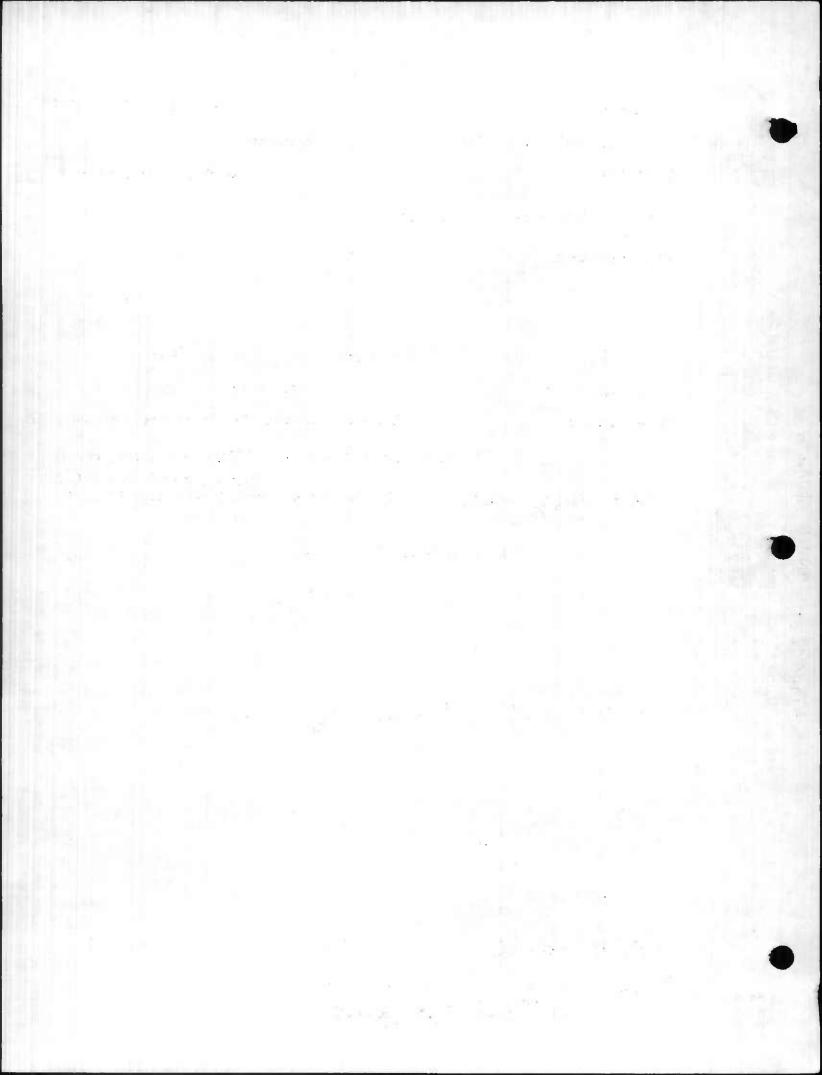
State

Registrar

31. Date filed (Month, Dey, Year)

JAN 2 0 1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death REUBEN JANHARY 17 1998 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death RANDALLSTO WN BALTIMORE NORTHWEST HOSPITAL 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number Birthplaca (Stata or Foreign Country) 1 X M 2□ F Months Days Hours 216-14-7308 Yrs. NOV. 16, 1921 MD Usual Rasidanca of Dacadani 10c. City, Town or Location 10d. Inside City Limits 10h County MD BALTIMORE BALTIMORE 1 ☐ Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 7518 PRINCE GEORGE ROAD 21208 U.S.A. 12. Was Decedant Evar in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc 1 Yas 2 No 1 ☐ Nevar Married 2 ☐ Married If Yes, Giva AIR FORCE 1□ Yas 2X No Specify: 3 X Widowed 4 ☐ Divorced WHITE 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT use ratired) Elamantary/Secondary (0-12) College (1-4or 5+) OWNER/OPERATOR TAXICAB 18 Mothar's Nama (First, Middle, Maidan Surnama) 17. Fathar's Nema (First, Middla, Last) JOSEPH WALL FRIEDA RANKIN 19b. Malling Addrass (Streat end Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) FRADA WALL / DAUGHTER 9953 MIDDLE MILL DRIVE - OWINGS MILLS, MD 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Date 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from State Donation 5 Othar (Specify) HEBREW FRIENDSHIP CEMETERY 1/19/99 BALTIMORE, MD 22. Nama and Addrass of Facility 21. Signature of Funaral Sarvice Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23e. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Betwaan Onset and Death immediata Causa (Final disaasa or condition resulting in deeth) Dua to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performad? 1 Yas 2 No 1 Yas 2200 26. Pleca of Death (Chack only ona) Hospital: 1 ☑ npatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify)

**Physician** /Medical Examiner

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To the Hospital or within 24 hours at To the Funeral Di completaly filled in

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

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with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: if Item 27 is merked other than "natural", or items 23s or 28s-1 show way lighty or other traumatic event, the Medical Enablined from the fraction on the formal contraction.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Ceuse (Diseese or Injury that Initiated avants rasulting in daath) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was cesa referred to madical axaminar? 1 Yas 2 No

28a. Data of Injury (Month, Day Year) 27. Mangar of Death 1 Natural 5 Panding 2 Accidant investigation 6 Could not be datamined 3 ☐ Suicida

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28c. Injury at Work? 28b. Tima of

1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

28d. Describe how injury occurred

29a. Certifier

4 Homleide

1 GCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and manner stated. 29d. Data signed (Month, Day, Year) 29c. Licansa number

29b. Signatura and titla of certifie

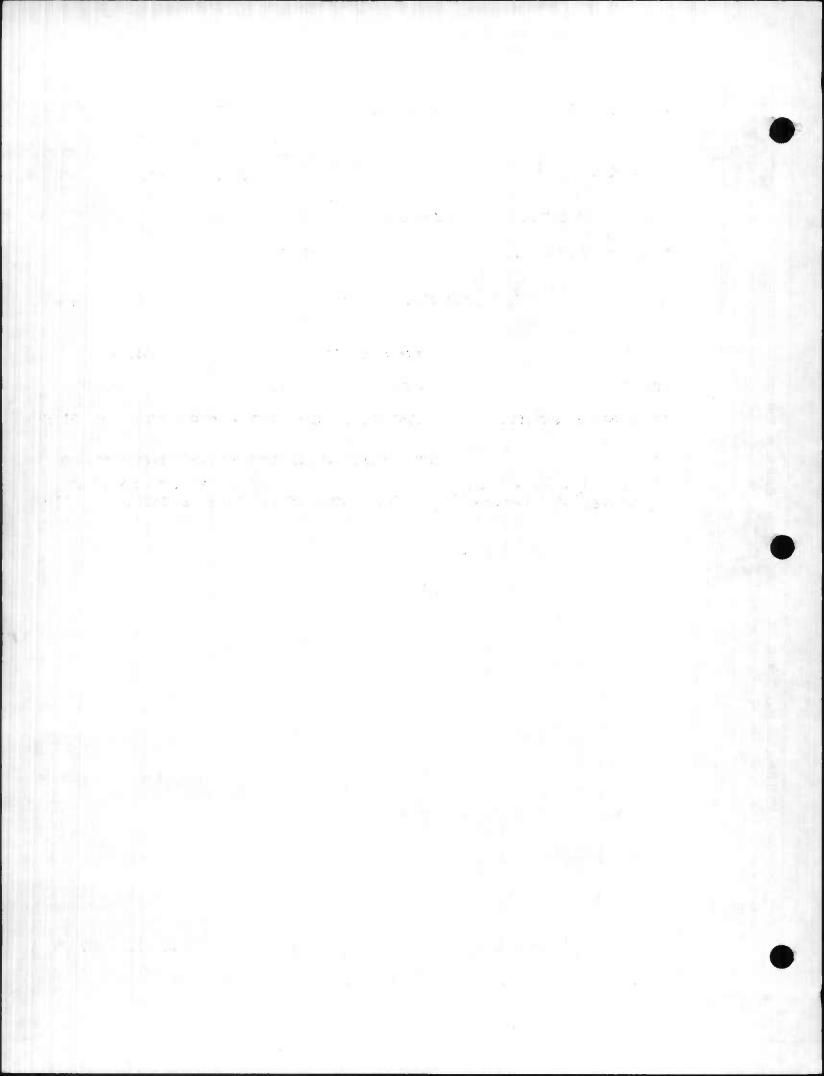
JANUARY 17, 1999

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

MD, NHC RAVI.

BALTIMORE MO

State Registrar 31. Deta filad (Month, Day, Year) 32 Registrar's Signatura 1999



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 2-3-4abc-10c-10f Per PHY Film G767 1-19-99 ricertificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month 1-11-99 12:30 A.M. 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 24 Brookbury Dr. Apt. 1A Reisterstown Baltimore If Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) 5. Social Sacurity Number 10 M 20 F If Under 1 Year 9. Birthplaca (Stata or Foraign 6. Sex 7. Age (In yrs. last birthday) Days 219-58-3629 Usual Rasidenca of Dacedent 76 Yrs. MAY 29,1928 Marylana 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Baltimore Maryland Reisterstown 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? U. S. A. Road 24 Brookebur 2436 21133 Was Dacedent of Hispenic Origin? (Specify Yas or No-lf Yes, specify Cubas, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. Was Decedant Evar in U.S. Armed Forcas? 11. Marital Status 1 Yas 2 No If Yes, Give Yaar or Datas: 1 Nevar Married 2 Married 1 Yas 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elemantary/Sacondary (0-12) Collega (1-4or 5+) Nursing Home assistant 17. Fathar'a Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Roy Conway Gertrude Hodge 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Nama/Ralationship (Type, Print) Bathmore Co. 21117 Pittston Circle 190 Frederick G. Wilson Husbard 20c. Location - City or Town, Stata Bai Timore County 20a. Mathod of Disposition

1 Deurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Nama of cematary, cramatory or other place) Garrison Forest Vet. Cem Jan 20,99 Maryland 4 ☐ Donation 5 ☐ Othar (Specify) A. Grayson Funeral Service Liberty Road. Balto Co. MD 21244 21. Signatura of Funaral Sarvica Licansee 22. Nama and Addrass of Facility muld 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death Immediate Cause (Final disaasa or condition rasulting in daath) Myocardia ona Sequentially list conditions, if any, leading to immadiata ceusa. Entar Undarfying Causa (Disaasa or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of) Due to (or as a consequance of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contributa to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ena) Othar: 4 Nursing Homa 5 Residence 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 8 Other (Specify) 28e. Data of Injury (Month, Day Year) 27. Mannet of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending Invastigation

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Examiner

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pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic event, in Medical Exercise must be accurate and once.

Saltimore, Maryland 21215-0020

attending physician and for use as the burial-transit Physician/Medical is certificata has I

this funeral After

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: n 24 hours after death.

• Funers! Director: After the function of the functin To the Hosp within 24 hos To the Fune completaly fi

State Registrar 30. Nama and address of parson who completed cause of death (Itam 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of axaminetion and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(e) and manner stated.

29c. Licensa number

29d. Data signad (Month, Day, Year) 01/11/99

28f. Location (Street and Number or Rural Routa Number City or Town, Stata)

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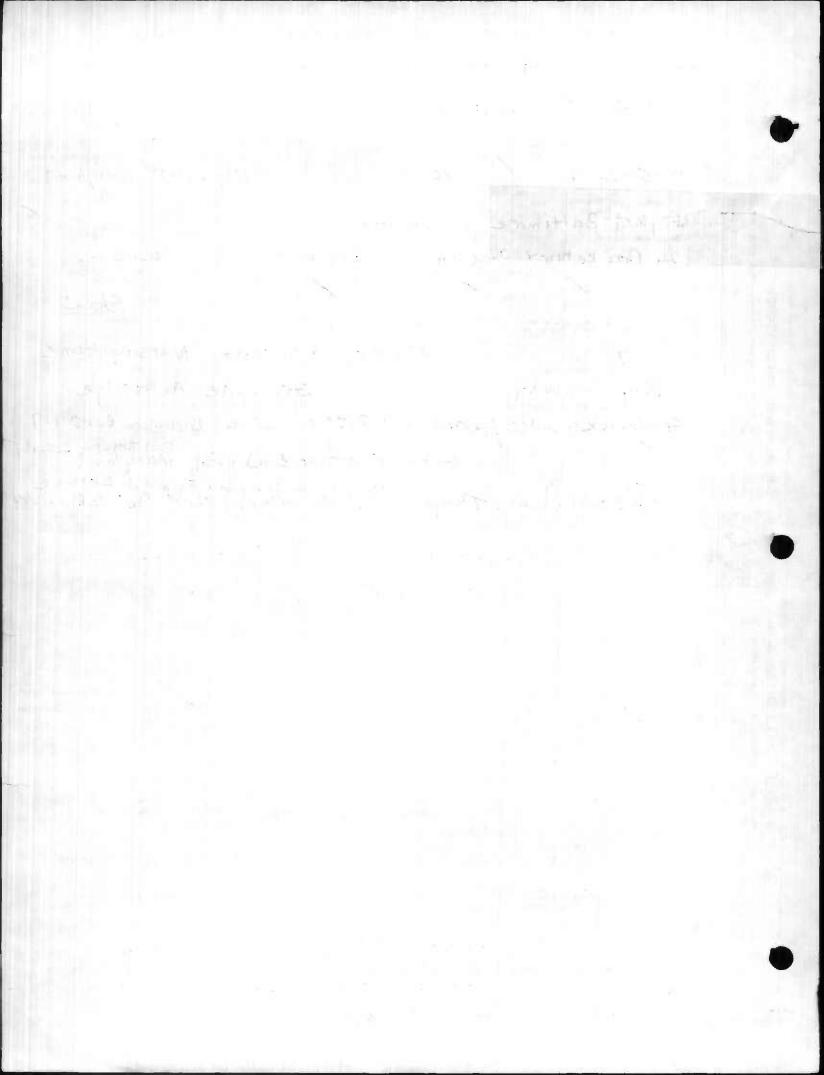
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Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133 Pegistrar's Signeture 31. Data filed (Month, Day, Year)

28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

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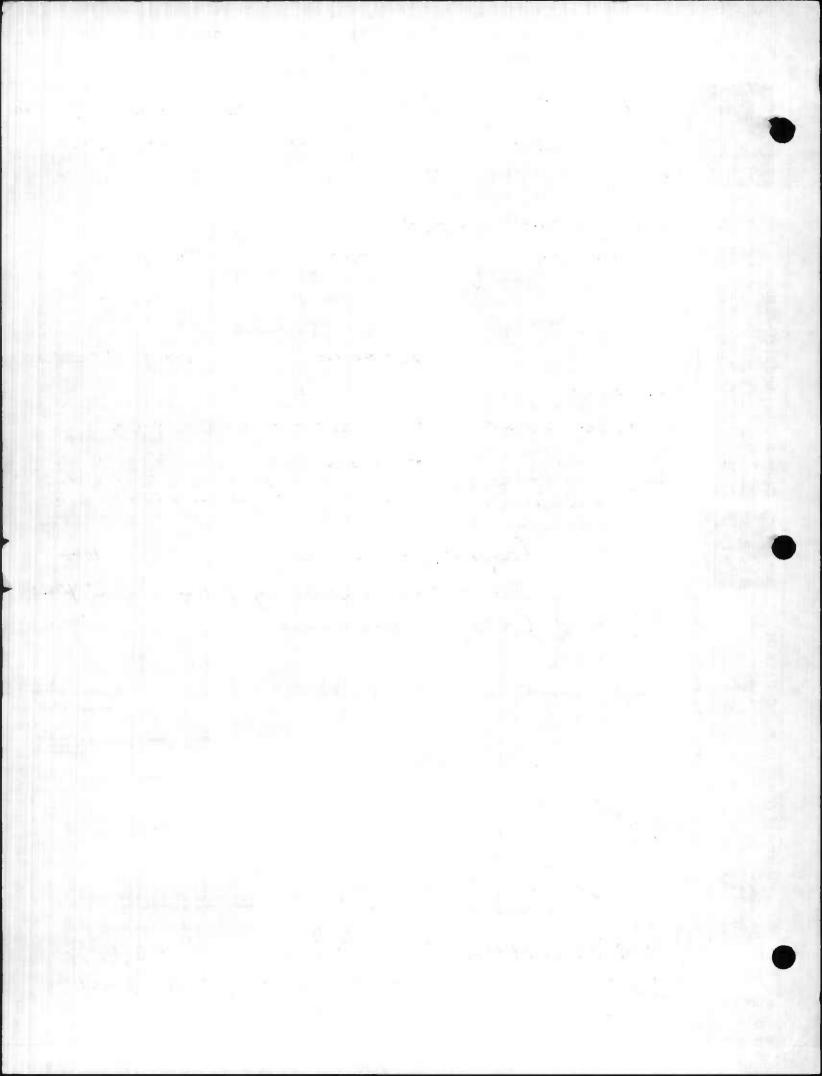


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State of Maryland / Department of Health and Mental Hygiene 0 0 9 9 7

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Due to (or as a consequence of):  Sequentially list conditions, any, leading to immediate exerts. Enter Underlying Cause (Disease or injury that Initialized exertise in the conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of deeth 1.  1   Yes   2   No   3   Probably   4   Unknow    24a. Was an autopsy performed?  25. Were case referred to medical exercise examination of cause of deeth 1.  1   Yes   2   No   1   Yes   2   No    25. Were case referred to medical exercise examination of cause of deeth 1.  1   Yes   2   No   1   Yes   2   No    25. Were case referred to medical exercise examination of cause of deeth 1.  26. Place of Death (Check only one)  27. Manager Peart II. Other significant conditions contribute to the cause of deeth 1.  28b. Did tobacco use contribute to the cause of deeth 1.  1   Yes   2   No   1   Yes   2   No    25. Were case referred to medical exercise examination of cause of deeth 1.  27. Manager Peart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  28b. Did tobacco use contribute to the cause of deeth 1.  1   Yes   2   No   3   Probably   4   Unknown of the cause of deeth 1.  28b. Place of Death (Check only one)  28b. Place of Death (Check only one)  28b. Place of Death (Check only one)  28c. Date of Injury - At home, ferm, street, factory, office  28c. Causer (Check only one)  28c. Causer (Check only one)  28c. Place of Injury - At home, ferm, street, factory, office  28c. Causer (Check only one)  28c. Date of Injury - At home, ferm, street, factory, office  28c. Causer (Check only one)  28c. Date of Injury - At home, ferm, street, factory, office  28c. Causer (Check only one)  28c. Date of Injur		disease or condition		mos					
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Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.    23b. Did tobacco use contribute to the cause of death   1   yes 2   No 3   Probably 4   Unknow   24a. Was an autopsy performed?   24b. Were autopsy findings available prior to completion of ceuse of death?   1   yes 2   No   1   yes 2   No   1   yes 2   No   1   yes 2   No   1   yes 2   No   1   yes 2   No   1   yes 2   No   1   yes 2   No   1   yes 2   No   1   yes 2   No   1   yes 2   No   1   yes 2   No   25b. Time of injury Mork?   26b. Date of Injury Mork?   26b. Date of Injury Mork?   26b. Date of Injury Mork?   26b. Date of Injury At Death   1   yes 2   No   26b. Date of Injury At Death   26b. Date of Injury	on the sea	d							
24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of ceuse of death?  1	. 6 6 6 .	Part II. Other significant conditions contributing to death but not resulting	ig In the underlying ceuse given in Part I.	23b. Did tobacco use contri	buts to the cause of death?				
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25. Wes cese referred le medical examinar?    1   Yes 2   No	1 9 4 8 8 A 1			1□Yes 2⊟No	1 Yes 2 No				
29a. Certifier (Check only Check	Italiant dant of the color.	25. Wes cese referred to medical	26. Place of	Death (Check only one)					
27. Manner of Death    Order   Check only	l die	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpetient 3□ DOA Other: 4□ Nursin	g Home 5 Residence 6 Other	(Specify)				
29a. Certifier (Check only and title of certifier (Check only and manner stated.)  29a. Certifier (Check only and manner stated.)  29b. Certifier (Check only and manner stated.)  29c. Licansa number (Check only and manner stated.)  29d. Data signed (Month, Day, Year)				28d. Describe how injury occurred					
	DIVIS	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home building, etc. (Specify)	o, ferm, street, factory, office		or Rural Route Number,				
	Hospi Na hou Funer tely fill		dge, deeth occurred et the time, date and pt and/or Investigation, In my opinion, death o	ace, and due to the cause(s) end menn occurred at the time, date and place, and	er es steted. d due to the ceuse(s)				
	of the complete of the complet	No. 41 Control of the	29c. Licansa number	29d, Data signed (i	Month, Dey, Year)				
	P 5 P D	Holor Clork new hun	D 11653	You 5	1000				
Name and address of person who completed ceuse of death (Itam 23a) (Type, Print)			Ba) (Type, Print)	11/1/22	7799				
31. Date field (Month, Dev. Year) 1000 32. Conistrar's Signature	State	100		nnapolis, MD, 2	1401				

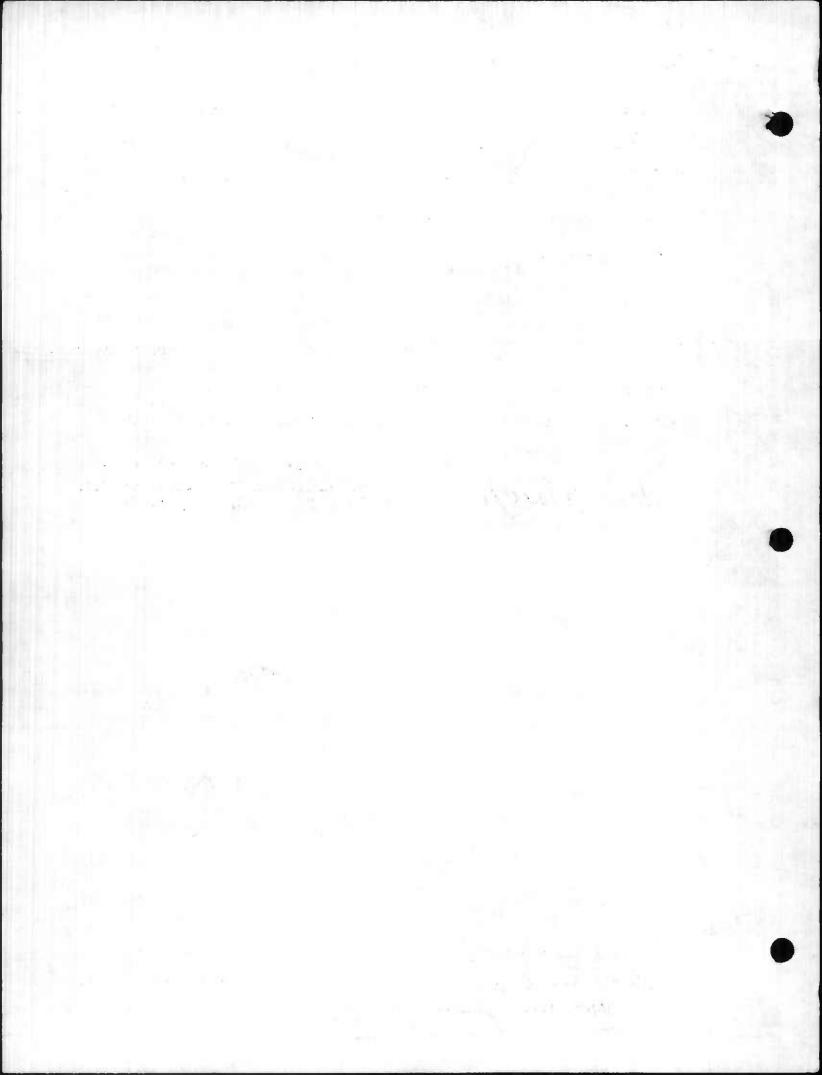
DHMH 16 Rev 6/95



n 24 hou. he Funeral Dir. Hospital To the Hosp within 24 ho To the Fune completely fi

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and titla of certifian 29c. License number 29d. Date signed (Month, Day, Year) M O.C.M.E. January 13, 1999 address of person who completed causa of death (Item 23a) (Type, Print) WCKE (ON) 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Data tiled (Month 1999 32. Registrar's Signatura

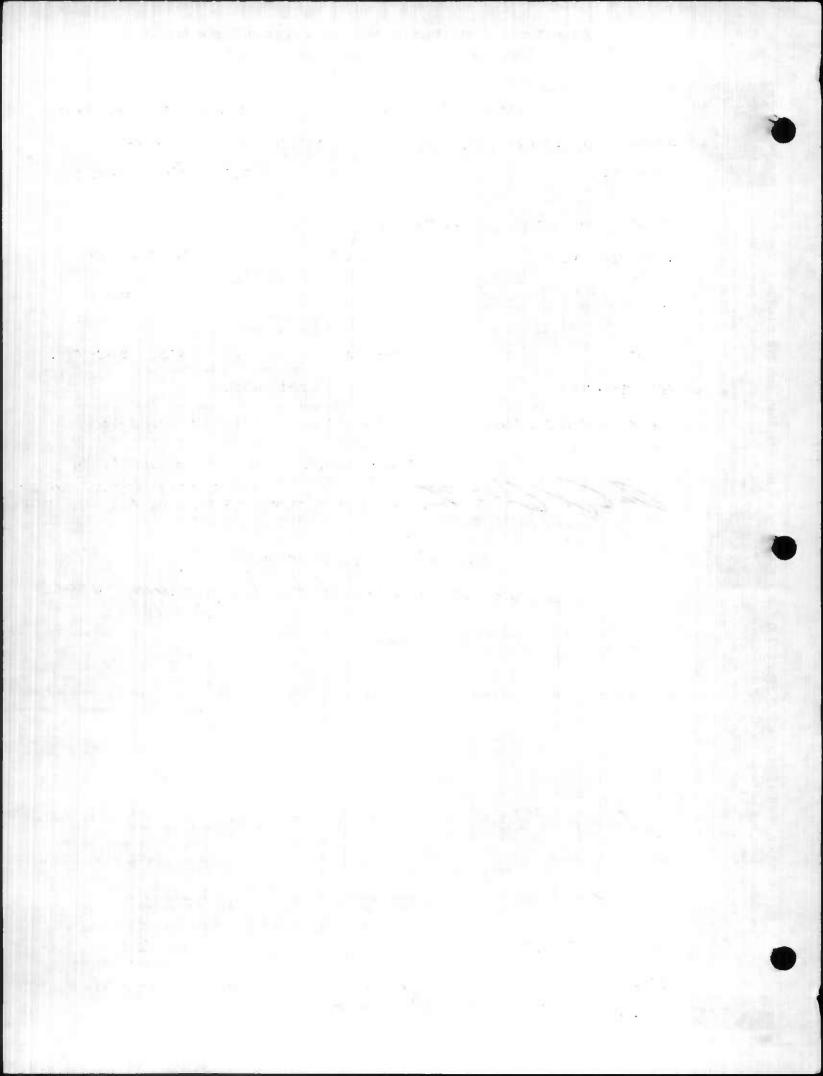


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State of Maryland / Department of Health and Mental Hygiene 0 0 0 0 0

							C	ertificate d	of E	Death		Reg. No.	O			
	Physician		Decedent's Name (First, Middle, Last)						2. Date of D Month			Day Yeer		3. Time of Death 9:05am		
gr.	/Medical	ELSIE P, BELL														
	Examine		WILLIAM HILL	MANOI	R ASSIS	TED CA	RE		E	ASTON		TALBOT				
	Funeral Director		5. Social Security Number 215 07 5684	6. Sex		Age (In yrs.		Months Da		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De) DCT 02	, Yeer) , 1909	9. Birth Cou MAR	plece (Stete or Foreign ntry) Y LAND		
	pue *	-	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits				
	deeth with the Maryland ms 23a or 28a-f show met 23a or 20a-f show	5	MARYLAND OUEEN	ANN	ES	QUEENSTOWN								1 ☐ Yes 2 No		
	vith the Mar t or 28s-f s be notified		10e. Street and Number	222727		7.4		10f. Zip Cod	de	****		10g. Citizen of	Whal Cou	intry?		
	23a 123a		100 CARRIAGE L	-					21658			UNITED STATES				
P # E			11. Merital Status  1 □ Never Merried 2 □ Ma  3 ☑ Widowed 4 □ Divorce	12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes:		,S. 1	<ol> <li>Was Decedent of Hispanic Origin? (S         if Yes, specify Cuban, Mexican, Puert         1 ☐ Yes 2 ☒ No Specify:</li> </ol>			rto Rican, etc.)		. Race - American Indien, Bleck, White, etc. pecify: WHITE				
2-0	72 ho		15. Decede (Specify only high	cation 16a. Decedent'			cedent's Usuel Ocive kind of work do	ccupa	ation Juring most of worki	ing	16b. Kind of B	usiness/ir	ndustry			
21215-0020	led within 72 ho tygiene. her than "naturi nt, the Medical.		Elementary/Secondary (0-12)	- 1	College (1-4	or 5+)			etired)	uring most of worki		MASONRY	CON	TD A CTOD		
9	tal Hygie d other t event, th	3	12 17. Father's Name (First, Middle	, Last)	0		DOOL	KEEPER		18. Mother's Neme				IRACIOR		
Maryland	should be filed and Mental Hygi marked other imatic event, I		EMIL PFEIFFER							DORA RE	NNERT					
lan	and h		19a. informant's Name/Relation				19b. M	ailing Address (Sta	reet e			umber, City or Town, State, Zip Code) WN , MD . 21658  20c. Location - City or Town, State				
	l end lealth m 27 her tr		BURTON B, BEI	L JR	. (SON)	20h I		CARRIAG		LANE QUE	ENSTOWN	/				
Itimore,	Peges 1 nent of 1- mr. If ite iry or ot	1	20a. Method of Disposition  1 ■ Burial 2 □ Cremetion		emoval from Ste	le (	cemetery, o	remetory or other	plece							
altin	permit. Peg Department Important: I any Injury o	-	4 □ Donation 5 □ Other  21. Signeture of Funeral Service		n -/	CI	EDAR	BLUFF CEI 22, Name end Ac			-07-99	ANNAPO	LIS,	MD.		
	Physician /Medical Examiner		23a. Pert1. Enter the disease, shock, or heert failure. Li Immediate Ceuse (Final disease or condition resulting in deeth)	or complies only on	cations that cau e ceuse on eed	robe	h. Do not	enter the mode of	dylng	E GLOUCES g, such es cardiac and a	or respiretory a	ANNAL C		MD, 21401 Approximete Intervel Between Onset end Death  Vlasf		
	2 0 0	3.1	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	<b>\</b>				sequence of):			all	10ity				
Box	death certi		Pert II. Other significant condi	fons con	tributing to deat	h but not res	sulting in th	e underlying cause	e aive	en in Pert I.	23b. Did	lobacco use co	ntribute	to the cause of death?		
s, P.O	v requires that the death cer been signed by the attendir should be deteched for use		Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in								1  Yes 2 No 3 Probably 4					
Records,	2 25 2	- David									24a. Wes	an autopsy rmed?	9	Vere autopsy findings wallable prior to completion of cause of death?		
Œ	The page	5									10	res 20 No	1	☐ Yes 2☐ No		
Vital	Physicien: The this certificate ral director, pag		25. Wes case referred to medic exeminer?		lospital:				Othe	ar. /	26. Plece of Death (Check only one)					
ō	his hy		1 Yes 2 No  27. Menner of Deeth 1 Neturel 5 Pend 2 Accident invest	atient 2□ njury Day Year)	28b. Time of linjury 28c. In			4 Winsing Ho	g Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred		ify)					
Division	tal or Attending P is effer death.  al Director: Affer t led in by the funera		3 ☐ Suicide 6 ☐ Coul	d not be mined	28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or I within 24 hours effer To the Funeral Dire completely filled in b					s of examine				ne, date and place, pinion, deeth occurr						
	To the comp		290. Signature and title of certifier						29c. License number 29d. Dete signed (Mon					o, Dey, Year)		
			30. Neme end eddress of person		mpleted cause of	of death (Ite	m 23a) (Ty	pe, Print)	1/6	2 Aug	East	in m	DZ	1601		

State Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	n	Decedent's Nema (First, Middle, Le     MARGARET	st)	RI	JETTNER		f Death	2. Deta of De Month JANUA	Day	Yeer	Time of Death								
Medica xamine	_	4e. Facility Nama (If not institution, giv			2222121		4b. City, Town, or	1			.00 IM								
kallille			CARE				SEVERNA				1.00								
neral	- 1	5. Sociel Security Number 6. S 217-03-8917	ех 7. A	ge (In yrs. 36	last birthday) Yrs.	If Undar 1 Yea Months Deys	r If Under 24 Hrs	s. 8. Dete of Bi	rth ey, Year)	9. Birthplece Country) MARYLAN	(Stete or Foreign								
14	1	Usuel Residence of Decedent  10e. Stete 10b. County		10c. Cit	y, Town or Loc	pation				10d. Ir	nside City Limits								
notified at	jo l	MARYLAND		ВА	LTIMORE	Ξ				2	Yes 2 No								
lon no	Director	10e. Street and Number 10f. Zip Code							10g. Citizen of	10g. Citizen of What Country?									
ner must b		44 McKEWIN AVENUE 21218							U.S.A.										
EXBI	by Funeral	11. Marital Stetus  12 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedant Armed Forces  1  Yes 2  If Yes, Give Year or Datas:	?		/as Dacedent of Yas, specify Cu □ Yas 2€ No	Hispenic Origin? (sban, Mexican, Pua Specify:	Specify Yes or No rto Rican, etc.)	5 14. Rac Bia Specifi	ce - American Inck, White, etc.  y:  WHITE	dian,								
US MENTAN	mpieted	Completed	15. Decedent's Et (Specify only highest gra Elementery/Secondery (0-12)			life. DO NOT		of work done during most of working IOT use retired)			16b. Kind of Business/Industry  BEAUTICIAN								
		7. Fether's Neme (First, Middle, Last)					18. Molher's Na	8. Molher's Name (First, Middla, Maidan Surneme)											
inc a		CONRAD	BUET	CNER			MARY KIRSCHNER												
P P		19e. Informent's Neme/Reietlonship (	Type, Print)		19b. Meilin	Address (Stree	et end Number or F	Iural Route Numb	er, City or Town,	, State, Zip Code	9)								
once.	- 1	EVELYN M. VAIL- N	IECE		201		AVENUE,	N.E., G											
		20e. Method of Disposition  1   ☐ Burial 2 ☐ Cremetion 3 ☐  4 ☐ Donetion 5 ☐ Other (Specification)		0	emetery, crem	ition (Neme of etory or other pl		Data 1 / 1 1 / 9 9		City or Town, S									
once.	1	4 Donetion 5 Other (Specify) MOST HOLY REDEEMS 21. Signature of Funeral Service Licensee 22. Name end Addre																	
	4	23e. Pert1. Enter the disease, or comphock, or heart failure. List only	Tofb		1	SECOND	AVENUE,	S.W., GL	EN BURN	IE, MD 2	21061								
es the bur	edic	ledical	Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Last	· Kerry · Corry	Due to (o	culvre	wt fa	ilure		- V									
	5	Part il Other elanificant conditions o					ina la Dani I	ant Did	***										
	Completed by Physician/N	ò	ò	2	þ	2	ò	2	2	Part il. Other significant conditions contributing to death but not resulting in the underlying cause give							23b. Did tobacco use contribute to the cause of d		
nieted																			
s certificate has director, page 2	5							1 🗆	Yes ZINO	1 □ Yes	2 No								
200	0	25. Wes case referred to medical exeminer?	t to only to					eth (Check only	one)										
_   _	-	1 Yes 2 No	Hospitel: 1 Inpati	- 1	ER/Outpatient 28b. Time of	3LI DUA		Home 5 Resi											
d in by the funerel di		27. Menner of Deeth  1 Naturel 5 Pending 2 Accident Investigation	M 1	ury et ork? □ Yes 2 □ No	28d. Describe	ibe how injury occurred													
100	5	3 Suicide 6 Could not be	28e. Piece of In building, et	ury - At ho c. (Specify	ome, farm, stre /)	et, fectory, office		City or To			te Number,								
0 0		4 Homicide determined																	
0 0		29a. Certifier (Certifying Physics)	rstolan: To the best iner: On the basis o end menner st	f exeminal	wiedge, deeth tion end/or Inve	occurred et the t estigetion, in my	ime, dete end plece opinion, deelh occ	e, and due to the urred et the time,	cause(s) and me dete end plece,	enner es stated. end due to the o	cause(s)								
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led in by the		29a. Certifier (Check only one) 1 Certifying Physics (Check only one)	end menner st	f exeminated.	Physica	29c. Licen	opinion, deeth occ	urred et the time,	29d. Date signe	end due to the d									

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